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IN THE

Supreme Court of the United States

OCTOBER TERM 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner
v.
KENNETH DONALDSON,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE RESPONDENT

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	v
OPINION BELOW	1
QUESTIONS PRESENTED	1
STATEMENT OF THE CASE	2
A. Introduction	2
B. Facts	2
1. Respondent was committed to Florida State Hospital in January, 1957, for the purpose of treatment.	3
2. Petitioner knew that respondent received no treatment, and that respondent received only custodial care.	5
3. Despite the inadequate staffing and resources at Florida State Hospital, there were standard modes of treatment that were available, but were not provided for respondent.	10
4. Petitioner knew respondent was not dangerous to himself or to others.	14
5. If released, respondent would have been able to provide for his basic needs in the community: he did not need custodial care.	19
6. Petitioner knew he had the authority, as attending physician and later as superintendent, to release respondent.	22
7. Petitioner did not take the steps he could and should have taken to release respondent, and instead, intentionally blocked respondent's attempts to be released to the supervision of responsible friends and organizations.	24
SUMMARY OF ARGUMENT	31
ARGUMENT	33

TABLE OF CONTENTS—Continued

Page

I. UNDER THE DUE PROCESS CLAUSE, RESPONDENT, WHO WAS INVOLUNTARILY CONFINED AS MENTALLY ILL UNDER NON-CRIMINAL STANDARDS AND PROCEDURES FOR FIFTEEN YEARS AND WHO WAS DANGEROUS NEITHER TO HIMSELF NOR TO OTHERS, HAD A RIGHT TO BE RESTORED TO LIBERTY EITHER BY TREATMENT OR ELSE BY RELEASE 33

A. Respondent's Involuntary Civil Commitment Abridged His Constitutionally Protected Liberty 41

B. The Stated Purpose of Respondent's Involuntary Confinement Was To Provide Him With Treatment for His Mental Illness in Order To Return Him to the Community 44

1. As petitioner knew, the stated purpose of respondent's confinement was to provide treatment so that respondent would be returned to the community. 45

2. Custodial care of a mentally ill person who is neither dangerous to himself nor to others is not a constitutionally permissible purpose for involuntary confinement. 47

3. This Court should not hold that provision of treatment justifies involuntary confinement of a harmless mental patient. 54

C. Due Process Required That the Nature of Respondent's Involuntary Confinement Had To Be Reasonably Related to the Purpose of That Confinement: Respondent Thus Had a Constitutional Right to Treatment Or to Release 56

TABLE OF CONTENTS—Continued

Page

D. Definition of the Right to Treatment: The Trial Court Properly Instructed the Jury That Respondent Should Have Received Such Treatment As Would Have Given Him a Reasonable Opportunity To Be Cured or To Improve His Mental Condition 60

1. The instructions defining the right to treatment were correct. 61

2. The evidence showed, and the jury could have found, that respondent did not receive treatment which would have provided a reasonable opportunity to cure or improve his mental condition. 63

3. Standards defining the right to treatment can be developed in other cases by using the traditional tools of the judicial process. 64

II. IN THE CIRCUMSTANCES OF THIS CASE, THE AWARD OF COMPENSATORY AND PUNITIVE DAMAGES SHOULD BE AFFIRMED 74

A. No Legal Issue Regarding Damages Is Before This Court Because Petitioner Did Not Object to the Relevant Jury Instructions, Either at Trial or on Appeal 75

1. The good faith and reasonableness defense. 75

2. The "retroactivity" claim. 76

B. The Jury Instructions Relevant to the Award of Damages Were in Accord With Applicable Law 77

1. The good faith and reasonableness defense. 77

2. The "retroactivity" claim. 79

TABLE OF CONTENTS—Continued

	Page
C. The Award of Compensatory and Punitive Damages Is Supported by the Evidence	82
D. Affirmance of the Award of Damages Will Not Disrupt Florida's Mental Health System	84
E. Petitioner's "Waiver" Argument Is Not Properly Before This Court, and Is Without Merit	85
CONCLUSION	88

TABLE OF AUTHORITIES

Cases:	Page
Adickes v. *S. H. Kress and Co.*, 398 U.S. 144 (1970)	76, 79
Anderson v. *Nosser*, 456 F.2d 835 (5th Cir. 1972)	80
Arnett v. *Kennedy*, 94 S.Ct. 1633 (1974)	41
Atlantic & Gulf Stevedores, Inc. v. *Ellerman Lines, Ltd.*, 369 U.S. 355 (1962), *rehearing denied*, 369 U.S. 882 (1962)	50
Baker v. *Carr*, 369 U.S. 186 (1962)	61
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Baxstrom v. *Herold*, 383 U.S. 107 (1966)	31, 43
Bivens v. *Six Unknown Named Agents*, 456 F.2d 1339 (2d Cir. 1972)	78
Blanks v. *Cunningham*, 409 F.2d 220 (4th Cir. 1969)	72
Board of Regents v. *Roth*, 408 U.S. 564 (1972)	42
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Brady v. *Southern Ry. Co.*, 320 U.S. 476 (1943)	51
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Continental Ore Co. v. *Union Carbide and Carbon Corp.*, 370 U.S. 690 (1962)	51
Davis v. *Watkins*, No. C 73-205 (N.D. Ohio, Sept. 1974)	36, 58
Davy v. *Sullivan*, 354 F. Supp. 1320 (M.D. Ala. 1973)	37
Director of Patuxent Institution v. *Daniels*, 243 Md. 16, 221 A.2d 397, *cert. denied*, 385 U.S. 940 (1966)	37
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TABLE OF AUTHORITIES—Continued

Page

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Easter v. *District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966) 72
Eastman Kodak Co. of New York v. *Southern Photo Materials Co.*, 273 U.S. 359 (1927) 50
Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 44
Galloway v. *United States*, 319 U.S. 372 (1943) 51
In re Gault, 387 U.S. 1 (1967) 51, 52
Gomes v. *Gaughan*, 471 F.2d 794 (1st Cir. 1973) 37
Great No. Ry. v. *Sunburst Oil & Refining Co.*, 287 U.S. 358 (1932) 76
Greenwood v. *United States*, 350 U.S. 366 (1956) 51, 52, 71
Gunning v. *Cooley*, 281 U.S. 90 (1930) 51
Handverger v. *Harvill*, 479 F.2d 513 (9th Cir. 1973), *cert. denied*, 414 U.S. 1072 (1973) 78
Harrison v. *Brooks*, 446 F.2d 404 (1st Cir. 1971) 78
Hawaii v. *Standard Oil Co. of California*, 405 U.S. 251 (1972) 48
Holt v. *Sarver*, 442 F.2d 304 (8th Cir. 1971) 72
Humphrey v. *Cady*, 405 U.S. 504 (1972) 31, 43, 51, 52, 57, 62, 63
Hvotavi v. *Vanderport*, 380 F. Supp. 645 (D. Minn. 1974) 80
Husty v. *United States*, 282 U.S. 694 (1930) 76
In re I, 316 N.Y.S.2d 356 (Fam.Ct. 1970) 37
Inmates of Boys Training School v. *Affleck*, 346 F. Supp. 1354 (D.R.I. 1972) 37
Jackson v. *Indiana*, 406 U.S. 715 (1972) 32, 33, 34, 44, 45, 49, 51, 56, 57, 62, 67
James v. *Strange*, 407 U.S. 128 (1972) 44
Jobson v. *Henne*, 355 F.2d 129 (2d Cir. 1966) 79
In re Jones, 338 F. Supp. 428 (D.D.C. 1972) 66
Jones v. *Perrigan*, 459 F.2d 81 (6th Cir. 1972) 78

TABLE OF AUTHORITIES—Continued

Page

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Kirstein v. *Rector & Visitors of University of Virginia*, 309 F. Supp. 184 (E.D. Va. 1970) 80
Landman v. *Royster*, 354 F. Supp. 1302 (E.D. Va. 1973) 72, 79
Lane v. *Wilson*, 307 U.S. 268 (1969) 79
Lawn v. *United States*, 355 U.S. 339, rehearing denied, 355 U.S. 967 (1958) 76
Linkletter v. *Walker*, 381 U.S. 618 (1965) 76
Lumberman's Mutual Casualty Co. v. *Elbert*, 348 U.S. 48 (1954) 51
Lynch v. *Baxley*, Civ. Action No. 74-89-N (M.D. Ala. Dec. 14, 1974) 56
M v. *M*, 71 Misc.2d 396, 336 N.Y.S.2d 304 (Fam. Ct. 1970) 37
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Martinez v. *Mancusi*, 443 F.2d 921 (2d Cir. 1970), *cert. denied*, 401 U.S. 983 (1971) 72
McCray v. *Maryland*, 456 F.2d 1 (4th Cir. 1972) 78
McKinney v. *DeBord*, 324 F. Supp. 928 (E.D. Cal. 1970) 80
McNeil v. *Director, Patuxent Institution*, 407 U.S. 245 (1972) 51, 57, 67
Meyer v. *Nebraska*, 262 U.S. 390 (1923) 44, 45, 56
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Mitchell v. *Boslow*, 357 F. Supp. 199 (D. Md. 1973) 78
Morales v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973) 37

TABLE OF AUTHORITIES—Continued

Page

Mormon Church v. *United States*, 136 U.S. 1 (1890) 48
Morrissey v. *Brewer*, 408 U.S. 471 (1972) 43
Murel v. *Baltimore City Criminal Ct.*, 407 U.S. 355 (1972) 51, 57, 62
Nason v. *Superintendent of Bridgewater State Hospital*, 353 Mass. 604, 233 N.E.2d 908 (1968) 37, 62
Nebbia v. *New York*, 291 U.S. 502 (1934) 44, 45, 56
Nelson v. *Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir. 1974) 37
New York State Association for Retarded Children, Inc. v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973) 36, 37
Nixon v. *Herndon*, 273 U.S. 536, 47 S.Ct. 446, 71 L.Ed. 759 (1927) 79
Papachristou v. *City of Jacksonville*, 405 U.S. 156 (1972) 43
Pierson v. *Ray*, 386 U.S. 547 (1967) 77, 78
Powell v. *McCormack*, 395 U.S. 486 (1969) 61
Powell v. *Texas*, 392 U.S. 514 (1968) 52
Ragsdale v. *Overholser*, 231 F.2d 943 (D.C. Cir. 1960) 53
Renelli v. *Department of Mental Hygiene*, 340 N.Y.S.2d 498 (1973) 36
Robinson v. *California*, 370 U.S. 660 (1962) 52, 53, 60, 72
Roe v. *Wade*, 410 U.S. 113 (1973) 42, 44, 55, 72
Rouse v. *Cameron*, 373 F.2d 451 (D.C. Cir. 1966) 66
Sas v. *Maryland*, 334 F.2d 506 (4th Cir. 1964) 37
Scheuer v. *Rhodes*, 416 U.S. 232 (1974) 77, 78, 79
Shapiro v. *Thompson*, 394 U.S. 618 (1969) 43, 55
Shelton v. *Tucker*, 364 U.S. 479 (1960) 43, 55
Silvers v. *People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970) 37
Southwestern Brewery & Ice Co. v. *Schmidt*, 226 U.S. 162 (1912) 50

TABLE OF AUTHORITIES—Continued

Page

Specht v. *Patterson*, 386 U.S. 605 (1967) 52
Stachulak v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973) 37
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Taylor v. *Perini*, 365 F. Supp. 557 (N.D. Ohio 1972) 80
Tenney v. *Brandhove*, 341 U.S. 367 (1951) 77
Tribby v. *Cameron*, 379 F.2d 104 (D.C. Cir. 1967) 66
Truax v. *Raich*, 239 U.S. 33 (1915) 43
United States v. *Jackson*, 306 F. Supp. 4 (N.D. Cal. 1971) 53
United States v. *Klein*, 325 F.2d 283 (2d Cir. 1963) 72
United States v. *Pardue*, 354 F. Supp. 1377 (D. Conn. 1973) 37
United States v. *Solomon, et al.*, Civ. Act. No. 74-181 (D. Md., filed Feb. 21, 1974) 36
United States v. *Walker*, 335 F. Supp. 705 (N.D. Cal. 1971) 37, 53
Vlandis v. *Kline*, 412 U.S. 441 (1973) 44, 45, 56
Welsch v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) 36, 53, 58, 65, 68
Wheeler v. *Glass*, 473 F.2d 983 (7th Cir. 1973) 78, 79
Whirl v. *Kern*, 407 F.2d 781 (5th Cir. 1969), *cert. denied*, 396 U.S. 901 (1969) 81, 83
Whitetree v. *State*, 56 Misc.2d 693, 290 N.Y.S.2d 486 (Ct.Cl. 1968) 72
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In re Winship, 397 U.S. 358 (1970) 31, 43
Winters v. *Miller*, 446 F.2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971) 80
Wright v. *McMann*, 460 F.2d 126 (2d Cir. 1972) 80, 84

TABLE OF AUTHORITIES—Continued

Page

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Wyatt v. *Stickney*, 325 F. Supp. 781 (M.D.Ala. 1971), *aff'd, sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Nov. 8, 1974) 36, 53, 58, 66
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York v. *Story*, 324 F.2d 450 (9th Cir. 1963) 80
Zenith Radio Corp. v. *Hazeltine Research, Inc.*, 395 U.S. 100 (1969) 51

Constitution:

Eighth Amendment 52, 56, 60
Fourteenth Amendment ..... *passim*

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18 U.S.C. § 4246 72
42 U.S.C. § 1983 77
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D.C. Code Annotated §§ 21-562 and 21-591 (1973) 85
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TABLE OF AUTHORITIES—Continued

Page

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TABLE OF AUTHORITIES—Continued

Page

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TABLE OF AUTHORITIES—Continued

Page

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TABLE OF AUTHORITIES—Continued

Page

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J. B. O'CONNOR, M.D.,
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KENNETH DONALDSON,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR THE RESPONDENT

OPINION BELOW

The Opinion of the Court of Appeals for the Fifth Circuit is reported at 493 F.2d 507.

QUESTIONS PRESENTED

1. Did respondent, who was involuntarily confined to a mental hospital for the purpose of treatment for nearly fifteen years, and who was dangerous neither to himself nor to others, have a constitutional right to be restored to liberty either by treatment or release?

2. Is there no evidence from which the jury could have concluded, as it did, that petitioner did not reasonably believe in good faith that respondent's continued confinement was lawful or proper, and that petitioner's acts were sufficiently malicious, wanton and oppressive to justify both compensatory and punitive damages?

STATEMENT OF THE CASE

A. Introduction

Petitioner O'Connor deprived respondent Donaldson of his liberty for nearly fifteen years, even though he was under no statutory or judicial obligation to do so. He did so even though he knew respondent was not dangerous to himself or to others. He did so even though he knew respondent was receiving only the same custodial care he would have received in a prison. And, having the authority to release respondent, he instead blocked respondent's efforts to be released to the custody of responsible friends and organizations. His acts, as a jury found, showed bad faith, and were so malicious, wanton and oppressive as to justify not only compensatory damages of $17,000, but punitive damages of $5,000.

Properly understood, this case raises important but narrow issues. In order to identify issues that are, and are not, raised by this case, it will be necessary to review the extensive facts developed at trial in some detail. Many of the "facts" contained in petitioner's brief are unsupported by any citations, and have literally no basis in the record. And petitioner has ignored material facts that were overwhelmingly established at trial.

B. Facts

From the evidence of record, the jury could reasonably have found the following facts:

1. Respondent was committed to Florida State Hospital in January, 1957 for the purpose of treatment.

Respondent's commitment papers, which accompanied him to Florida State Hospital, expressly stated that respondent was committed "to the Superintendent of the Florida State Hospital, Chattahoochee, Florida, for care, maintenance *and treatment*." Plaintiff's Exhibit No. 13, "Order for Delivery of Mentally Incompetent." (Emphasis added.)

That order, by itself, made it clear that respondent was to receive something more than mere custodial care. The order, in turn, was consistent with, and required by, the statutes in effect at the time of respondent's commitment, which leave no doubt that the statutory purpose of his confinement was treatment.

Title 27 Florida Statutes § 394.09 (Laws 1877, Ch. 3036 § 1) (repealed July 1, 1972), then in effect, provided that persons committed to "hospitals" were committed "for the purpose of care, custody *and treatment*. . . ." (Emphasis added.) The word "treatment" was not fortuitous. The same section provided that persons committed not to hospitals but to "any other person" were committed "for care, custody or maintenance. . . ."[1]

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[1] Title 27, Florida Statutes, § 394.21(1) (Laws 1945, Ch. 23157 § 3) (repealed July 1, 1972) provided that the "head of a hospital" could admit involuntary patients "for observation, diagnosis, care *and treatment* . . . ." (Emphasis added.) Title 27, Florida Statutes, §§ 394.21(6) and 394.22(13) (repealed July 1, 1972) authorized recovery from the estates of patients of "reasonable charges" for the "care, maintenance *and treatment*" of patients, and provided that advance payment could not be "a prerequisite to the care, maintenance *and treatment*" of patients in public hospitals. (Emphasis added.) In order to implement this legislative purpose, Title 27, Florida Statutes § 394.08 (Laws 1945, Ch. 22858 § 7) (repealed July 1, 1972) required the "superintendent of the Florida State Hospital" (that is, petitioner, for 7½ years of the period respondent was confined) to "cause" the chief physician to "keep a com-

In addition, in 1967, four years before respondent was discharged, petitioner promulgated the *By-Laws. Rules and Regulations of the Medical Staff of the Florida State Hospital* (cited hereafter as "Hospital Regulations"). Plaintiff's Exhibit 2, and answers 14-a, 14-b and 15 of petitioner's *Answers to Interrogatories* dated January 4, 1972. The Hospital Regulations (at 4) stated that Florida State Hospital "was established to provide a *treatment facility* for the mentally ill in the State of Florida," and provided further:

> "Generally, it is our responsibility to the patients *to provide the best psychiatric and physical care possible.* It is expected that all physicians shall, at all times, conform with the ethical standards of medical practice. *Our primary objective is to return the patients as useful citizens, to their own community, as soon as possible. The mental hospital should only be an intermediate step in the treatment and rehabilitation of the patient.* Aside from providing the *best standards of treatment*, it is the responsibility of every physician to encourage and participate in whatever hospital programs in which he is asked to participate." Hospital Regulations at 54. (Emphasis added.)

The Hospital Regulations stated that the "*superintendent is responsible* . . . for the proper management of the hospital in order *to insure the best possible care and treatment* for the patients." Hospital Regulations at 55. (Emphasis added.)

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plete clinical record of each patient, which record shall contain the name of the patient, the diagnosis, the date of beginning of *each treatment*, each day's prescription while under *treatment*, and such other therapy as may be indicated." (Emphasis added.) Subsequent statutes, effective in 1965 and 1967 (respondent was released July 31, 1971), continued to speak in terms of "treatment." *E.g.*, Title 27, Florida Statutes, §§ 394.272 (Laws 1965, Ch. 65-23 § 1) and 394.201 (6)(a) and (b) (Laws 1967, Ch. 67-7 § 4) (repealed July 1, 1972).

In summary, the court order which committed respondent, the statutes under which he was committed, and the Hospital Regulations all show that respondent was confined for the purpose of treatment.

2. Petitioner knew that respondent received no treatment, and that respondent received only custodial care.

Respondent's first witness was Dr. Walter Fox, an unusually distinguished psychiatrist, who had intimate knowledge of the standards applicable in public mental hospitals during the period of respondent's confinement.[2] Dr. Fox was asked, for the period 1957-1967, if there was evidence in respondent's hospital record that respondent "received psychiatric treatment." He replied (A at 2; T 11/21/72 at 65-66):[3]

> "A. No. In my opinion *there is no evidence that he received psychiatric treatment.* There are a number of progress notes which are generally brief and which make no reference to a treatment plan which frequently refer to continue custodial care or words

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[2] At the time of trial, Dr. Fox was Director of Mental Health Services for the state of Arizona. He had served as superintendent of public mental hospitals in Kentucky (1956-1965) and Iowa (1966-1972), and for two years as President of the Association of Medical Superintendents of Mental Hospitals (1968-1970). Accordingly, he was intimately familiar with the problems and the capacities of public mental hospitals during the period respondent was confined, and his evaluation of respondent's hospital record was made in that context. Dr. Fox is a Diplomat in Psychiatry of the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association. T11/21/72 at 59-64.

[3] "A" refers to the Appendix. "T" refers to the transcript of trial. Because there are several transcripts, each for a separate day of trial, and they are not all consecutively paginated, citations to the transcript are followed by the date of the particular transcript to which reference is being made. There are two transcripts for the final day of trial. The one which primarily reproduced the "oral charge" to the jury is so designated (T Oral Charge 11/28/72). "H" refers to respondent's hospital record, which was received in evidence as Plaintiff's Exhibit No. 1.

to that effect, which I interpret to mean provide food, clothing and shelter, and that is not psychiatric treatment." (Emphasis added.)

The very first progress note in respondent's hospital record, written nearly three months after admission by co-defendant John Gumanis, says "continue custodial care." A at 199; H at 64. That note was written while petitioner was respondent's attending physician, and thus directly in charge of respondent's care. Petr. Brief at 6. Twenty-one months later, in another progress note, co-defendant Gumanis repeated the order to "continue custodial care." A at 199(a); H at 64. Similar orders to continue custodial care were written by co-defendant Gumanis on March 21, 1959, April 23, 1959 (all while petitioner was respondent's attending physician), and on April 3, 1962. A at 200(b); H at 64-65. According to a progress note signed by a Dr. Chacon on August 30, 1965, nearly nine years after his admission, respondent was still receiving only "custodial care." A at 201(a)(i); H at 67. Gumanis testified, and petitioner did not deny, that custodial care would not help a paranoid schizophrenic, the diagnosis applied to respondent by petitioner. A at 113-14; T 11/27/72 at 38. A co-defendant, Dr. Walls, testified that respondent only received "milieu therapy," and that "custodial care is what we now call milieu therapy." A at 142-43; T 11/27/72 at 118-20. A letter Walls wrote on June 2, 1970, confirms this is what "milieu therapy" meant at Florida State Hospital. H at 838-40.

Petitioner knew that an adequate hospital record, containing an individualized treatment plan and frequent progress notes, is an essential prerequisite to treatment, and he knew that respondent's hospital record was inadequate (*see*, Florida Statutes § 394.08, note 1, *supra*,

requiring a "complete clinical record"), and could not serve as the basis of a treatment program.[1]

Dr. Fox, who in the previous two years had been called upon as a "consultant for the National Institute of Mental Health" to examine 400-500 patient records "to determine whether or not they were adequate records," and "whether or not the patients described in those records were receiving adequate treatment," testified that respondent's record was not an adequate record. A at 1, 10; T 11/21/72 at 64-65, 77-78. For example, Dr. Fox testified that he found "no evidence" of an "individualized treatment plan" in respondent's hospital record during the first ten years of his confinement (A at 4; T 11/21/72 at 69), even though "a treatment plan is basic to discharging a person." A at 10; T 11/21/72 at 78. Petitioner testified that respondent's treatment plan "would be incorporated no doubt in progress notes made by the patient's attending physician." A at 172; T 11/28/72 at 46. But during the period he was respondent's attending physician, petitioner did not "incorporate" a treatment plan in respondent's progress notes. In fact, he entered *nothing* in respondent's record. A co-defendant testified that it was petitioner's practice not to make "any notes." A at 105; T 11/27/72 at 11.

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[1] The Hospital Regulations promulgated by petitioner provided that "the attending physician shall be responsible for an adequate record of the patient . . . ." Article XI, ¶ 7. The specified purpose of the Hospital Regulations was "to insure that all patients admitted to the hospital receive the best possible care." Article II, ¶ 1. To that end, the Regulations required that an "individual comprehensive treatment plan [be] recorded, based on an inventory of the patient's strengths as well as his disabilities . . . ." Article VII, § 8, ¶ 5, Factor 8. The individual treatment plan was required to include "a substantiated diagnosis," "short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnosis and for the treatment and rehabilitation activities carried out." *Id.*

That practice, according to Dr. Fox, was contrary to the "standard practice in mental hospitals" under which a note would be entered in the record after each "significant contact" with a patient. A at 11-12; T 11/21/72 at 79.

The most vivid description of the prison-like custodial conditions in which he was forced to live from 1957 to 1967 comes from respondent's testimony (A at 40-44; T 11/22/72 at 245-48):

"Q. Now, in the buildings you lived in in Department A, were those buildings locked?
A. Yes, sir.
Q. Were the wards you lived on locked?
A. Yes.
Q. Were there metal enclosures on the windows?
A. Yes, padlocks on each window.
Q. Approximately how many beds were there in the rooms where you slept?
A. Some sixty beds.
Q. How close together were they?
A. Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.
Q. Did you have chairs in the dormitory areas?
A. There wasn't a chair in the room I was in.
Q. All right, was there an outside exercise yard for your department?
A. Yes, there was a space outside the building, a good sized space enclosed with a cyclone fence topped with barbwire.
Q. Did you go out to that exercise yard?
A. I went out from time to time when the other patients went out.
Q. Was there ever a period of time when you did not go out to the exercise yard?
A. Yes, there was one period in particular when nobody went out for two years.

Q. Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?
A. That is right.
Q. Were there criminal patients on your ward?
A. There were criminal patients on the ward.
Q. Approximately what percent of the population on your ward were criminals?
A. Looking back, roughly, I would say a third. I do not know the figures for the whole department.
Q. Let's talk just about your ward.
A. Okay. I would say about a third in the wards I was in.
Q. Now, did you sleep in the same rooms as the criminal patients?
A. Yes.
Q. Did you get up at the same time?
A. Yes.
Q. Did you eat the same food?
A. Yes.
Q. In the same dining room?
A. Yes.
Q. Did you wear the same clothes?
A. Yes. The entire operation of the wards I was on was geared to the criminal patients.
Q. Let me ask you, were you treated any differently from the criminal patients?
A. I was treated worse than the criminal patients.
Q. In what sense were you treated worse?
A. The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.
Q. For the criminal?
A. On the criminal patients, and that would be a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.
Q. Was there a place on the ward you had access to for keeping personal possessions?
A. No, not at that time.

Q. What did you do with your personal possessions?
A. I kept mine in a cedar box under the mattress of my bed.
Q. Was there a place in the wards where you could get some privacy?
A. No, not anytime in all of the years I was locked up.
Q. Were you able to get a good night's sleep?
A. No.
Q. Why not?
A. On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night. They never did, but you think about those things. It was a lunatic asylum."

Accordingly, the jury could have concluded that petitioner knew respondent lived on a locked ward, with criminal patients, and received only the "custodial care" he would have received in a prison.

3. Despite the inadequate staffing and resources at Florida State Hospital, there were standard modes of treatment that were available, but were not provided for respondent.

Petitioner knew respondent did not receive even those types of treatment that *were* available at Florida State Hospital.

Grounds privileges. Since the express goal of hospitalization, as stated in the Hospital Regulations, was to restore the capacity for independent community living, one of the most basic forms of treatment was to give patients an increasing degree of independence and personal responsibility. Co-defendant Walls confirmed that

Florida State Hospital "often" gave "grounds privileges" to the involuntary male patients, which allowed them to walk around the hospital's extensive grounds unattended. T 11/27/72 at 106. Dr. Fox testified that confining respondent to a locked building, with no opportunity for grounds privileges, was inconsistent with a psychiatric treatment plan for him. A at 4; T 11/21/72 at 70. Further, even in "an institution with limited resources" it would have been "standard psychiatric practice . . . in the case of Mr. Donaldson" to give him "grounds privileges," "weekend passes" and "trial visits for a month or two." A at 13-14; T 11/21/72 at 80-81.

Twice in 1957 petitioner approved respondent's assignment to institution-maintaining work assignments but crossed out that portion of the work assignment forms which would have given respondent grounds privileges while on the way to and from work. A at 193(a)-(b); H at 13-14.[5] Respondent specifically requested grounds privileges, but co-defendant Gumanis denied his request. T 11/22/72 at 240-41; A at 200(b); H at 65. Gumanis testified that the decision to deny grounds privileges was made in consultation with petitioner. A at 118; T 11/27/72 at 42. In fact, Gumanis testified that respondent "never" had grounds privileges during his ten years in Department A because Gumanis "consulted the superintendent" (petitioner), who "advised" Gumanis "not to give any." A at 118; T 11/27/72 at 42. No reason for the denial is contained in the hospital record and, although the matter was in dispute, no explanation was offered at trial. When respondent later came under Dr. Hanenson's care in Department C, Dr. Hanenson gave him grounds privileges. T 11/22/72 at 271.

[5] Copies of various documents retyped by petitioner for use in the Appendix are incomplete or inaccurate. For example, petitioner's signature and the denial of grounds privileges show quite clearly on the original work forms but do not show up on the retyped copies of the work forms used in the Appendix.

Occupational Therapy. Dr. Fox also testified that even with the "limited resources" of Florida State Hospital, petitioner could have assigned respondent to Occupational Therapy, which, given respondent's "social history," would have been an "excellent" treatment mode. A at 14-15; T 11/21/72 at 81-82.[6] Petitioner admitted that the hospital had a "well-regulated occupational therapy program" (T 11/28/72 at 36), and he knew from the hospital record (A at 201(i)) that his co-defendant Gumanis had denied respondent's request to be assigned to Occupational Therapy. No reason for the denial is contained in the hospital record and, although the matter was in dispute, no explanation was offered at trial. Within a month of his transfer to Dr. Hanenson's care (A at 202(b)(i); H at 70), respondent was permitted to engage in Occupational Therapy. *Id.*; T 11/22/72 at 271.

Contacts with physicians. Petitioner also knew that respondent's contacts with physicians were infrequent and administrative rather than therapeutic in nature. According to respondent's testimony, which petitioner did not dispute, during the period that petitioner was "directly responsible" for respondent's care, petitioner only spoke to respondent six times, less than one hour in all, and asked only the same three questions in each interview. T 11/22/72 at 216-19, 224, 241. The questions were: "What ward are you on?" "Are you taking any medication?" "Are you working any place?" A at 36; T 11/22/72 at 241. Respondent testified, again without contradiction, that he requested permission "many times" to speak with petitioner, but petitioner refused to speak with him. A at 38-39; T 11/22/72 at 243-44. Even if petitioner refused to speak with respondent only because petitioner was overworked (and there is no claim or evidence that that was the reason), the refusals surely demonstrate petitioner's awareness that respondent rarely spoke with physicians. In fact, the refusals are relevant not only to show that petitioner knew respondent was not receiving treatment, but also as evidence of petitioner's bad faith. As petitioner testified, there were "numerous opportunities [for the attending psychiatrist] to work out the patient's problems." T 11/28/72 at 35. Thus, the jury could have concluded that at least some of petitioner's refusals to speak with respondent could constitute evidence of bad faith.

[6] The work respondent performed was not the equivalent of occupational therapy, which teaches patients new employment skills. Petitioner never claimed that respondent's work assignments were, or were intended to be, therapeutic. Nor could he. Respondent's work requests were initiated by non-medical staff (*see*, H at 13-14), and were solely for the benefit of the institution. Respondent received no pay, and performed only menial tasks, such as dumping garbage, mopping floors, making beds, digging ditches, and helping retarded residents take showers. A at 45-51; T 11/22/72 at 249-54. The work assignments made it impossible for respondent to participate in occupational therapy, group therapy, or other treatment modes. For example, during his kitchen assignment, respondent worked "seven days a week" "from 6:00 o'clock in the morning to 7:00 o'clock that night," and was "locked in the kitchen all of that time." A at 48; T 11/22/72 at 252.

Social Services. Petitioner testified that the patient's physician "could, at his discretion, be aided by the efforts of a social service worker . . . ." T 11/28/72 at 35. But petitioner chose not to use that available service. In 1958, the Social Service Department received a letter from respondent stating he was not "receiving treatment of any kind." A at 206(a); H at 238. The Social Service Department brought that claim to petitioner's attention and asked if petitioner wanted "to refer this patient to Social Service." A at 206(b); H at 239. Even after this express offer, petitioner declined to utilize the proferred services of the Social Service Department. A at 206(b); H at 239.

In response to the overwhelming evidence that respondent received no treatment, and did not receive even those forms of treatment that were available, petitioner *now*

claims, although he did not so claim or testify at trial, and cites in his brief to no evidence in the record to support that claim, that respondent "did participate in milieu therapy, religious therapy and recreational therapy." Petr. Brief at 10. Respondent has shown that, at Florida State Hospital, "milieu therapy" meant no more than "custodial care." A at 142-43. Petitioner's co-defendant John Gumanis conceded at trial that "religious therapy" meant that respondent "could have gone to church," and that "recreational therapy" meant little more than that respondent "could have amused himself any way he wanted." A at 96-97; T 11/22/72 at 470-71. Even if religion and recreation could be considered "therapy," and were available for other patients, there is no indication in respondent's hospital record that such therapies were ever prescribed for respondent. To the contrary, at least to the extent that physical exercise is a form of recreation, there was evidence that for two years respondent was not even permitted to "go out to the exercise yard." A at 41-42.

From this evidence the jury could have concluded that petitioner knew respondent did not receive even those modes of treatment that were available at Florida State Hospital, and that petitioner even "unjustifiably withheld . . . specific forms of treatment" from respondent. 493 F.2d at 513.

4. Petitioner knew respondent was not dangerous to himself or to others.

As respondent will demonstrate *infra* (pp. 39-40), under the instructions in this case, the jury could not have returned a verdict for respondent unless it first found that respondent was not dangerous to himself or to others, and that petitioner *knew* that respondent was not dangerous. There was ample evidence to support that finding.

The trial court did not determine whether, under Florida law, a finding of dangerousness was prerequisite to involuntary and indeterminate commitment, and the commitment papers which accompanied respondent to Florida State Hospital (Plaintiff's Exhibit No. 13) are sketchy and inconsistent on the issue of dangerousness.[7] However, even if the commitment papers could have justified a belief that respondent was dangerous at the time of commitment, petitioner knew that it was his responsibility to review whether respondent continued to be dangerous.[8]

Following respondent's hospitalization, the evidence that he was not, in fact, dangerous to himself or to others,

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[7] Respondent was committed under Title 27, Florida Statutes, § 394.22(11)(a): "Whenever any person who has been adjudged mentally incompetent requires confinement or restraint to prevent self-injury or violence to others, the said judge *shall* direct that such person be committed . . . ." (Emphasis added.) Thus, the judge was *required* to commit dangerous persons, but he may have had the *authority* to commit non-dangerous persons. The commitment papers, though inconsistent and composed primarily of "boiler-plate," suggest that respondent might have been committed even though he was not considered to be dangerous. For example, the actual "Order For Delivery" of respondent to Florida State Hospital provided that respondent required "confinement or restraint to prevent self-injury or violence to others, *or* to insure proper treatment . . . ." Plaintiff's Exhibit No. 13. (Emphasis added.) Thus, respondent may have been committed solely to insure proper treatment. Respondent did not challenge his original commitment, but it should be emphasized that respondent did not, and does not, concede that he was dangerous at the time of commitment. It was not necessary to litigate that issue because under the theory of this case the jury had only to find that *after* commitment respondent was not dangerous, and petitioner knew he was not dangerous.

[8] Petitioner conceded that although the hospital superintendent need not "question the right or wisdom of a court in committing a patient," it was the "duty" of the superintendent "to determine whether the patient having once reached the hospital was in such condition as to suggest that he be considered for release from the hospital." A at 164-65; T 11/28/72 at 24; there is a typographical error in the retyped copy of p. 24 used as p. 165 of the Appendix.

was overwhelming. Petitioner admitted he had no knowledge or recollection that respondent had ever injured anyone, or been arrested for or convicted of any crime. A at 128; T 11/27/72 at 84. Petitioner had neither personal nor second-hand knowledge of *any* occasion during respondent's hospitalization when he either committed or threatened to commit any act that was or would have been dangerous to himself or others, and admitted that "as far as I know, plaintiff was not harming anyone else." A at 127; T 11/27/72 at 82. Letters petitioner wrote[9] stated that respondent was "cooperative" (H at 182), and "causes no particular trouble in management." H at 185. In 1957, petitioner approved respondent's assignment to work in the kitchen, and expressed no concern that respondent would thereby gain access to knives and other dangerous implements. A at 193(b); H at 14.[10]

Experts testified that there was "no evidence" anywhere in respondent's hospital record to indicate that he "ever hit anyone or ever even threatened anyone verbally" (A at 3; T 11/21/72 at 69; Dr. Walter Fox); and that "the overwhelming impression of the test results and the hospital record was of non-violent behavior and non-probability of any kind of acting out behavior." A at 65; T 11/22/72 at 395; Dr. Raymond Fowler.[11]

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[9] The initials below the signature block on carbons of letters written at Florida State Hospital are the initials of the person who dictated or wrote the letter. Defendants' Exhibit 4, p. 8; T 11/22/72 at 456. Thus, while the letters referred to in text were signed by the Clinical Director, petitioner wrote them, as the JBOC initials indicate.

[10] Also, petitioner apparently read a hospital form (H at 220) which stated that respondent was not considered to be dangerous. T 11/27/72 at 82; H at 221-223.

[11] At the time of trial, Dr. Fowler, a Ph.D. psychologist, was Chairman of the Psychology Department at the University of Alabama, and past President of the Alabama Psychological Association and the Southeastern Psychological Association. He was a member of the Council of Representatives of the American Psychological Association (APA), and a Fellow and Diplomat of APA. He had developed a computer system for the scoring of the Minnesota Multiphasic Personality Index ("MMPI") that had been used by "approximately a third of the psychiatrists in private practice" in the United States, and that was used to grade or diagnose "about 75,000 [patients] a year." Dr. Fowler was qualified as an expert in clinical psychology, particularly in the field of interpreting the MMPI and other psychological tests. T 11/22/72 at 373-82.

Petitioner was intimately familiar with respondent's case and record,[12] and the jury could have concluded that he must have been aware of the uniform opinion of those who dealt with him that respondent was not dangerous. Co-defendant Gumanis conceded he did not think respondent was dangerous. A at 120-21; T 11/27/72 at 44. Julian Davis, Director of the Psychology Department at Florida State Hospital, confirmed at trial (T 11/22/72 at 364-65) his earlier opinion, expressed in a psychological report (H at 62), that respondent was not dangerous and that continued hospitalization was unnecessary. Co-defendant Walls, a psychiatrist at Florida State Hospital, agreed that respondent was not physically dangerous to self or others. A at 141; T 11/27/72 at 118, 126. And a Dr. Rodriguez confirmed in a progress note in February, 1971 that respondent had "never been a violent patient." A at 205(a).

John H. Lembcke, a Certified Public Accountant, college classmate, and close friend of respondent and his family for 46 years (T 11/21/72 at 119-20), who had personally discussed respondent's case with petitioner (T 11/21/72 at 125), testified that respondent was a "gen-

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[12] Petitioner wrote all outgoing correspondence concerning respondent from March 30, 1957 to July 15, 1959. H at 180-259. And from October 12, 1959 (H at 264) through June 25, 1963 (H at 496) virtually all correspondence concerning respondent went out over petitioner's signature. *See also*, as additional evidence of petitioner's continuing and extensive involvement with respondent's case, H at 67, 68-69, 382-83, 407, 482, 525, 538, 539, 554, 576, 656, 662, 679, and 749.

tle" man who had never been "violent," "belligerent," or "aggressive." T 11/21/72 at 133-34. Finally, respondent testified that he had never injured or threatened to injure himself or others. A at 34; T 11/21/72 at 179.

In summary, as the Court of Appeals noted, "there was no evidence in the record of Donaldson's ever having been violent in any way . . . the jury would have been justified in finding that Donaldson was non-dangerous, and in inferring that the defendants knew him to be so." 493 F.2d at 517.[13]

[13] Moreover, the jury could have found that respondent showed bad faith in falsely representing to others that other staff members considered respondent to be dangerous. For example, at the end of a staff conference on January 9, 1964, petitioner summed up by saying that the "consensus of opinion" was that respondent was "considered to be dangerous to others." A at 196(a); H at 33. However, co-defendant Gumanis, who had directed that staff conference (A at 195; H at 32), testified that the statement that respondent was dangerous was petitioner's "personal opinion." A at 81; T 11/22/72 at 447. No other doctor had expressed that opinion, as the stenographic record of the meeting reveals (A at 195-196(a); H at 32-33), and no evidence of dangerousness had been presented to the staff. T 11/22/72 at 447-49. Dr. Walter Fox, after reviewing the records of the staff conference, pointed out that petitioner, "the last person to speak," was "the first one to use the word dangerous," which petitioner then falsely described as the "consensus of opinion". T 11/21/72 at 111-14. When asked about that statement, petitioner, who admitted he had no personal knowledge that respondent was dangerous (A at 127-28; T 11/28/72 at 82-84), claimed that he was only "summing up the consensus of opinion expressed by others on the staff" and the opinion "of Doctor Franklin Calhoun, the psychologist from Jacksonville who examined the patient." A at 131-32; T 11/28/72 at 87-88. Of course, according to Gumanis and to the staff minutes, the staff had not said anything at all about dangerousness. And petitioner could not possibly have relied on Calhoun's opinion, as he claimed, because Calhoun did not even examine respondent until February 22, 1964, 44 days *after* the January 9, 1964 staff conference. H at 520-25, 530-32; Defendant's Exhibit No. 1 at 5. When petitioner reported the results of this staff conference to a state legislator interested in respondent's case, he again falsely claimed that it was the "unanimous" opinion of the staff that respondent "even may present some degree of danger to others." A at 214-15; H at 526-27. Petitioner also claimed that

5. If released, respondent would have been able to provide for his basic needs in the community: he did not need custodial care.

There was evidence from which the jury could have concluded that respondent was not so mentally ill as to require long-term involuntary confinement for his own welfare.

Dr. Fox testified that he found no evidence in the record to justify a diagnosis of schizophrenia or, in any event, to justify 15 years of confinement. A at 30; T 11/21/72 at 68-69, 106. He noted that respondent "was always finding jobs and was not a welfare case." A at 13; T 11/21/72 at 80. As Dr. Fox pointed out (A at 5; T 11/21/72 at 70-71):

> "There was nothing in his past history that showed that he wasn't a generally self-sustaining if frequently moving individual. Everything would point to the fact that here was an individual who had made it pretty well, who was responsible, who did have regard for his fellow human beings, and right off you look at this guy as somebody to get out of the hospital very soon, and one of the ways you would do that is by giving him as much freedom as possible as soon as possible."

Respondent's case, according to Dr. Fox, "wasn't that complicated a case." A at 16; T 11/21/72 at 83. In fact, "given the positive steps that could have been taken to treat Mr. Donaldson *even in an institution with limited resources*" it was Dr. Fox's opinion that it would have been necessary to confine him for no more than "two or three months," and "it probably would take less. It

letter was based in part on Calhoun's examination (A at 133; T 11/27/72 at 89), even though the letter was dated January 9, 1964, 44 days prior to Calhoun's examination.

should take less." A at 16-17; T 11/21/72 at 82-83. (Emphasis added.)[14]

Dr. Raymond D. Fowler, Chairman of the Department of Psychology at the University of Alabama (see note 11, *supra*), reviewed respondent's record, including all of respondent's psychological tests and the underlying raw data. He found no evidence that respondent had been schizophrenic (A at 61; T 11/22/72 at 392), and testified further that "at least 10 percent and probably more" of all "college students would have profiles as deviant or more deviant than" respondent's on the Minnesota Multiphasic Personality Index ("MMPI") (A at 74; T 11/22/72 at 403); that the raw data from these examinations showed that respondent's behavior was "quite well organized" (A at 73; T 11/22/72 at 402); and that he "doubted" that he would ever have recommended hospitalization for respondent. A at 72; T 11/22/72 at 401.

Petitioner's co-defendant John Gumanis conceded that respondent "probably could have earned a living if he had gone out of the hospital." A at 113; T 11/27/72 at 37. In fact, after his discharge respondent took a bus to Syracuse, New York, where, within a week, he found a steady and responsible hotel job which he had held over a year by the time of trial. T 11/21/72 at 170-172. His employer, John Colozzi, testified that respondent "caught on very fast and very well," "conducted himself as a normal individual," showed up on time and never missed a day of work, ran the entire hotel from midnight until 8:00 a.m., balanced the accounts, received all monies, and "handled the job very well." T 11/21/72 at 159-168.

[14] Petitioner knew, as Dr. Fox pointed out on cross-examination, that when respondent had been hospitalized 14 years earlier at Marcy State Hospital, with the same diagnosis petitioner later applied to him, he had been released after only three months and had managed to care for himself and avoid re-hospitalization for the next 14 years. T 11/21/72 at 97-98; H at 1, 8, 30, 35, 64, 72.

There was additional evidence from which the jury could have concluded that respondent's mental condition did not change or improve during his fifteen-year confinement, indicating that he would have been equally capable of finding and holding a job throughout the period of his confinement. For example, Dr. Fowler testified that between 1958 and 1971, respondent's "test results were very much the same. . . . Specifically, the one that you can point to as a sort of an objective measure, the MMPI, looks about the same fourteen years later as it did previously." A at 62; T 11/22/72 at 393. Julian Davis, the hospital's psychologist, agreed with that conclusion, and agreed that respondent's mental condition, as reflected in the MMPI, was "basically the same" the day he was discharged as it was in 1958. A at 59; T 11/22/72 at 371-72. John Lembcke testified that respondent was, at the time of trial, "the same man that [he] knew back in college." T 11/21/72 at 134. And even petitioner agreed that there was no material change in respondent's mental condition during his hospitalization. T 11/27/72 at 81.[15]

From this evidence the jury could have concluded there was no reasonable basis to believe that, if released, respondent would not have been able to provide for his basic needs in the community.

[15] In addition, the jury was aware that, while confined, respondent wrote and published an article in a law review. T 11/22/72 at 277. The article, *Right to Treatment Inside Out*, 57 Georgetown L. J. 194 (1969), was offered but not received in evidence. The author of the article is identified only as a mental patient bearing hospital identification number A-25738, which was respondent's number at Florida State Hospital. A at 189.

6. Petitioner knew he had the authority, as attending physician and later as superintendent, to release respondent.

Petitioner concedes that he had the authority to grant respondent a "permanent" and unconditional release from the hospital if respondent had recovered. And there was evidence, see note 17 *infra*, that even if respondent had been mentally ill at the time of commitment, which respondent did not and does not concede, shortly thereafter the hospital staff recognized that respondent's alleged mental illness was "in remission," which would have allowed his release. Petitioner now claims, however, that he did not have the authority to release respondent on a "temporary" or conditional basis unless respondent had "recovered." Petr. Brief at 57; *see also*, at 4, 52, and 56. This claim was not advanced at trial, finds *no* support in the evidence, and is directly contrary to the evidence. In this section, respondent will show that even if petitioner thought respondent was still mentally ill, petitioner had the authority, both as attending physician and later as superintendent, to restore respondent to liberty by granting him a "temporary" or conditional release.

Throughout respondent's confinement there were two basic procedures for terminating hospitalization. The first, a "competency discharge," ordinarily required a "staff conference" and a determination by a majority of the medical staff that the patient had regained competency.[16] But the second procedure, which was variously described as a "trial visit," a "home visit," a "furlough" or an "out of state discharge," did *not* require a staff conference, and was *not* conditioned upon restoration of

[16] In fact, however, a staff conference was not essential, and, when a new superintendent replaced petitioner, in 1971, respondent was finally given a competency discharge without appearing before a staff conference. T 11/27/72 at 178-181; T 11/22/72 at 239.

competence. Every witness who testified confirmed these points.

Petitioner, for example, testified that "the typical trial visit was handled by the patient's attending psychiatrist." A at 163; T 11/28/72 at 22. A defense witness, Dr. W. D. Rogers, Director of the Florida Division of Mental Health, and Superintendent of Florida State Hospital from 1950 to 1963 (A at 148; T 11/27/72 at 144, 148), testified as follows (A at 150-51; T 11/27/72 at 150-51):

> "A. We have *always had in effect there a procedure for releasing a patient on a trial visit.* It was known as a trial visit. *This was a decision made by the treating psychiatrist.*
>
> "He can release the patient to *family, guardian or to some responsible person* who would assure the hospital of adequate care and supervision of the patient." (Emphasis added.)

Petitioner's co-defendant John Gumanis conceded that for "ordinary cases" the attending psychiatrist could release a patient on "furlough" without consulting the superintendent (A at 101-02; T 11/27/72 at 6), and confirmed that a patient could be released on furlough even if he had *not* regained competency and was still considered mentally ill. A at 100; T 11/27/72 at 5. Defendants' Exhibit No. 4, p. 10 (A at 242), the deposition of Dr. Rich, former Clinical Director at Florida State Hospital, confirms that even an "incompetent" patient "*could be released on trial visit strictly by his own doctor, without any other doctor being involved.*" (Emphasis added.)

In addition, petitioner's brief mischaracterizes trial visits as solely "temporary" in nature. Petr. Brief at 57. As Dr. Rogers testified, trial visits could be for a full year, at the end of which the released patient would be "discharged." A at 150-51. Co-defendant Gumanis

concurred. A at 100; T 11/27/72 at 5. Dr. Rich testified that Florida State Hospital did not even keep track of patients released on trial visit. Defendant's Exhibit No. 4 at 11. Finally, the Hospital Regulations (at 60) provided:

> "Some patients who suffer from recurring mental illness or who cannot be declared completely mentally competent are released from the Hospital in the care of a responsible relative or other individual for a period of twelve months.
>
> * * * *
>
> "Those patients who have been absent from the Hospital for twelve consecutive months are automatically discharged and removed from the Hospital census."

In summary, if petitioner had wanted to release respondent, he had the authority to do so.

7. Petitioner did not take the steps he could and should have taken to release respondent, and instead, intentionally blocked respondent's attempts to be released to the supervision of responsible friends and organizations.

Dr. Fox testified that the hospital record showed "for the first few years . . . almost an indifference to discharge. It was almost as if this was not one of the hospital's goals." [17] A at 6-7; T 11/21/72 at 72-73. Later,

[17] Petitioner's co-defendant Gumanis testified that if respondent's alleged illness had been "in remission," he would have been released from the hospital. T 11/27/72 at 21. But despite the fact that the first progress note in respondent's record stated that he "appears to be in remission" (A at 199), petitioner, then respondent's attending physician, made no effort to release him. Instead, petitioner responded to a contemporaneous inquiry from Travelers Aid in Philadelphia by saying that respondent would need "further hospitalization." H at 193. In March of 1957, while "in remission," respondent asked petitioner, then his attending physician, to initiate a staff conference at which other physicians could consider his release. H at 168-69. Petitioner refused.

however, Dr. Fox found "more than just indifference," he found "actual resistance to the discharge of Mr. Donaldson." *Id.* The resistance Dr. Fox described was most pronounced when outsiders attempted to have respondent released to their care.

Release to Helping Hands, Inc. On June 6, 1963, the president of Helping Hands, Inc., a halfway house for former mental patients, wrote a letter to Florida State Hospital which read, in part, as follows (A at 207; H at 494):

> "We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters."

Enclosed was a brochure describing Helping Hands (H at 492) and a letter from the Minneapolis Clinic of Psychiatry and Neurology (A at 206(c)-206(c)(i)) (described by petitioner's co-defendant as a "good clinic" (T 11/22/72 at 483)), which praised Helping Hands and expressed the opinion that "it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care" provided at Helping Hands. H at 493. Five days after that letter was received, petitioner replied that respondent could not be released to anyone other than his parents. A at 208; H at 495. The letter stated that respondent was then 55 years old. Petitioner therefore knew that respondent's parents were elderly, and he also knew they were quite infirm.[18]

[18] Almost every letter received from respondent's parents from mid-1959 on spoke of their failing health and of the incapacities of their age. H at 263, 274, 286-87, 290-91, 355, 452-53, 455-56, and 461. In February of 1960 they had written quite straight-

Defendant Gumanis admitted that "Helping Hands could have helped Mr. Donaldson." T 11/22/72 at 483. Gumanis testified that he "was of the opinion the patient would be helped from Helping Hands. I still think the patient could have been helped by Helping Hands." A at 108; T 11/27/72 at 14. He then testified that "the decision [to reject] was made by Dr. O'Connor, the Superintendent." A at 108-09; T 11/27/72 at 14. Earlier, Gumanis had testified that the "final decision" would have "laid with Dr. O'Connor." T 11/22/72 at 484. Petitioner, for his part, though admitting that he knew "nothing" about Helping Hands when he signed the rejection letter, claimed that "apparently," the decision to reject the Helping Hands offer was based on "the opinion of the attending physician" who was, at that time, co-defendant Gumanis. A at 134; T 11/27/72 at 90. The initials below the signature block indicate that they jointly drafted the rejection letter.[19]

Release to John Lembcke. On July 3, 1964, Mr. John H. Lembcke wrote petitioner to ask if there were "any conditions" under which respondent, whom he described as "a friend of mine," could be released to Lembcke's custody. A at 217; H at 540. Lembcke was not an irresponsible, intermeddling do-gooder. He was a married man, with three children, and, as his letterhead indicated,

forwardly that they thought they were "too old to be responsible" for respondent. H at 271.

[19] Moreover, the circumstances surrounding this rejection showed bad faith. Although the rejection letter claimed that respondent's parents were "legally responsible for him" (A at 208; H at 495-97), petitioner answered a contemporaneous letter from respondent's parents without even informing them of the Helping Hands offer. A at 209-11; H at 496-98. Gumanis placed responsibility for that omission on petitioner. A at 112; T 11/27/72 at 16-17. And elsewhere, petitioner expressly acknowledged that respondent could be released to someone other than his parents (A at 216(a); H at 539), despite his assertion to the contrary in the Helping Hands rejection letter.

was responsibly employed as a Certified Public Accountant. T 11/21/72 at 119. More importantly, he was probably respondent's oldest friend, and was known and respected by respondent's family, who had described him to petitioner as respondent's "pal and good friend." T 11/21/72 at 120, 136; H at 224-26. Nevertheless, the same day petitioner received Lembcke's request, without even mentioning the request to respondent, petitioner addressed to Gumanis a handwritten note which said: "Recommend turn it down." A at 216; H at 538. The note began by saying "This man himself [Lembcke] must not be well to want to get involved with someone like this patient . . . ." A at 216; H at 538. In his deposition submitted at trial, petitioner tried to minimize the importance of that note as "an off-hand remark made by one doctor to another doctor regarding a situation that had arisen calling for a decision to be made." A at 135-36; T 11/27/72 at 91. But it was that "off-hand remark" which caused Gumanis to draft a letter to Lembcke (A at 218), rejecting Lembcke's request. A at 85-86; T 11/22/72 at 457-58. Gumanis noted in respondent's record, under date of July 7, 1964: "A Mr. John Lembcke, a public accountant, wishes to sponsor him in New York, however Dr. O'Connor does not agree with this plan." A at 201(a); H at 67.

On November 24, 1964 petitioner received another letter from Lembcke asking to have respondent released to his care. A at 219; H at 553. The next day, petitioner instructed Gumanis to "please answer in negative." A at 220; H at 554. As reasons for this summary denial, petitioner listed a need for parental consent, the supposed unlikelihood of respondent's staying with Lembcke, and petitioner's lack of knowledge about Lembcke. *Id.* But petitioner never requested parental consent, and as will be seen below, the parents readily consented to releasing respondent to Lembcke's care when Lembcke subsequently requested consent. As in-

structed, Gumanis drafted another letter to Lembcke denying his request. A at 221; H at 555. He did not mention any of the reasons that petitioner had given, even though in his letter Lembcke had offered to "submit any information" that was needed. A at 219; H at 553. Gumanis testified that petitioner "told me to put it in a negative manner and that is exactly what I done." A at 93; T 11/22/72 at 468.

In May of 1966, Lembcke traveled from New York to Florida State Hospital, visited respondent, and talked with petitioner and Gumanis about respondent's release. T 11/21/72 at 125. Gumanis conceded that he "didn't see anything wrong with Mr. Lembcke" and "as far as I could tell," Lembcke "would have been adequate to manage Mr. Donaldson." A at 95. Lembcke also visited respondent's parents who, on May 14, 1966, jointly executed a notarized letter addressed to petitioner, in which they expressly gave "permission that our son, Kenneth Donaldson, be turned over to the care and supervision of John H. Lembcke." A at 228; Plaintiff's Exhibit No. 4. At that point, however, discouraged by his conversations earlier that week with petitioner and Gumanis, at which time they had refused to release respondent to his care (T 11/21/72 at 125, 138, 141), and aware that "Kenneth was exploring other ways to attain his release" (A at 227(a); H at 770), Lembcke did not pursue the matter further.

Finally, in 1968, when respondent was transferred to Dr. Hanenson's department, Hanenson called Lembcke long distance to arrange for respondent's release. T 11/21/72 at 125. He also scheduled respondent for a staff conference, which was not attended by petitioner. On March 21, the staff unanimously recommended that respondent be released "on trial visit or out of state discharge." A at 197; H at 47. There was some delay in working out the arrangements for release to Lembcke,

and in June of 1968 respondent wrote a letter to W. D. Rogers, by then Director of Mental Health for the State of Florida, asking if anything could be done to expedite the process. A at 225-26; H at 752. Dr. Rogers forwarded respondent's letter to petitioner, who apparently had no knowledge at that time of the staff plan to release respondent. Petitioner forwarded respondent's letter to Dr. Hanenson and asked Hanenson to give petitioner information about the contemplated release. Dr. Hanenson responded a few days later in a memorandum which explained and supported the staff plan for release to Lembcke. A at 224-224(a); H at 749. Across the bottom of that memorandum petitioner wrote, in his own hand, "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise the patient." H at 749; *see also*, A at 138; T 11/27/72 at 94.[20] When asked to do so, petitioner could not locate that decision in the hospital record (A at 139; T 11/27/72 at 94), and in fact, other than petitioner's notes to Gumanis, no such decision appears at any place in the record.

The staff plan to release respondent was thereupon abandoned and Lembcke was advised that respondent would not be released "at this time." A at 229; H at 775. That rejection letter imposed additional requirements, including "a more recent" parental release. As Lembcke put it, "after requirements were met, requirements were increased." T 11/21/72 at 132. From this evidence the jury could have found that the staff plan to release respondent was abandoned because of petitioner's discovery and disapproval of the plan. As the Court of Appeals noted, "the jury would have been justified in concluding that the frustration of Lembcke's effort to secure Donaldson's release in 1968 was en-

[20] The handwritten note was omitted when petitioner re-typed the memorandum for the Appendix (A at 224-224(a)), but appears clearly in the hospital record copy. H at 749.

tirely or primarily the result of O'Connor's bad faith intervention . . . ." 493 F.2d at 517.[21]

* * *

[21] There is further evidence in the record from which the jury could have concluded that petitioner willfully and maliciously blocked respondent's efforts to be released to the supervision of responsible friends and organizations because petitioner felt such efforts to be an attack upon his personal authority. During his confinement, respondent wrote letters to the Governor, to the state mental health commissioner, to state and federal legislators and judges, to lawyers, and to others, in nearly all of which respondent criticized conditions at petitioner's institution, and questioned the legality of his confinement. Those letters elicited personal replies from United States Senators Richard Russell and Stuart Symington, from George Meany, Governor Frank Lausche of Ohio, the editors of Time Magazine (who published one of respondent's letters) and others. T 11/21/72 at 203-04; Plaintiff's Exhibit No. 10. His letters also elicited inquiries from various officials, which caused petitioner to complain of "the constant burden of extra work [respondent] has placed upon the staff as a result of his baseless allegations . . . ." H at 681.

In fact, respondent's letters were not "baseless allegations" and were in part responsible for a legislative investigation of conditions at Florida State Hospital. On May 1, 1961, S. Chesterfield Smith, then Chairman of the Committee on State Institutions, and subsequently President of the American Bar Association, submitted a report that was highly critical of the hospital, noting that "the wards are maintained more as detention wards for inmates than they are as hospital wards for the sick." *Final Report of the General Findings of the Committee on State Institutions Relating to the Conditions at Florida State Hospital and the Alleged Mistreatment of Patients*, at 3.

Petitioner's own letters were preoccupied with, and constantly referred to, respondent's letters to public officials. *See*, for example, H at 232, 234, 239, 259, 382-83, 407-08, 483, 515-17, and 670-81. On at least one occasion, petitioner appeared to have initiated a search of respondent's hospital record to discover whether respondent had corresponded with a particular state legislator. *See*, H at 506. Thus, the jury could have concluded that petitioner was annoyed by respondent's challenge to his authority, and determined to continue respondent's confinement as punishment.

As the Court of Appeals noted, "there were suggestions in the record that Dr. O'Connor's conduct . . . was influenced by his knowledge of Donaldson's history of writing letters to the press and to outside officials." 493 F.2d at 517.

In summary, there was sufficient evidence for the jury to conclude that respondent was committed for the purpose of treatment; that petitioner knew respondent received no treatment; that petitioner knew respondent was not dangerous to himself or to others and would have been able to provide for his basic needs in the community; that petitioner knew he had the authority to release respondent but instead intentionally blocked his efforts to be released, and acted not only in bad faith, but also with malicious, wanton and oppressive disregard for respondent's rights and welfare. As the Court of Appeals ruled, "there was ample evidence" to support the jury's verdict. 493 F.2d at 513.

SUMMARY OF ARGUMENT

I.

Respondent was involuntarily committed to Florida State Hospital under non-criminal standards and procedures. Under the commitment order, the statutes then in effect, and the Hospital Regulations, respondent was confined expressly for the purpose of receiving treatment for his alleged mental illness. Petitioner knew that respondent was not receiving *any* treatment, and that he was receiving only the custodial care he would have received in a prison. Petitioner knew that respondent was not dangerous to himself or to others, and that respondent was capable of providing for his basic needs in the community. Petitioner had the authority to release respondent from the hospital, but instead allowed his confinement to continue for nearly fifteen years.

Involuntary commitment involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), and affects "fundamental rights." *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966). Avoiding such massive curtailment of fundamental rights is an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970).

The due process clause of the Fourteenth Amendment requires that the "nature" of confinement bear a reasonable relation to the "purpose" for confinement. *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972). Where, as here, the stated purpose for confinement is the provision of treatment, it follows under *Jackson* that confinement without treatment would not bear a reasonable relation to the purpose for confinement. Accordingly, in the circumstances of this case, respondent had a right under the due process clause of the Fourteenth Amendment to treatment or else to release.

II.

In order to award even compensatory damages, the jury had to find (a) that petitioner knew respondent was not dangerous; (b) that petitioner knew respondent received only custodial care; *and* (c) that petitioner did not reasonably and in good faith believe that respondent's continued confinement was lawful. Before awarding punitive damages, the jury had to find, in addition, that petitioner's acts constituted "extraordinary misconduct" and were "malicious, wanton or oppressive."

Petitioner did not and does not challenge the propriety of the instructions regarding the award of compensatory or punitive damages, and the instructions were in accord with applicable law. Because the jury found that petitioner *knew* his acts were unlawful, there is no issue of "retroactivity" in this case. There is, therefore, no issue of law regarding damages before this Court. The only issue regarding damages is the sufficiency of the evidence to support the jury's verdict. The Court of Appeals found "ample evidence" to support the verdict, and petitioner has suggested no reason why this Court should review, much less reverse, the jury's determination that petitioner acted in bad faith, with malicious, wanton and oppressive disregard for respondent's rights and welfare.

ARGUMENT

I. UNDER THE DUE PROCESS CLAUSE, RESPONDENT, WHO WAS INVOLUNTARILY CONFINED AS MENTALLY ILL UNDER NON-CRIMINAL STANDARDS AND PROCEDURES FOR FIFTEEN YEARS AND WHO WAS DANGEROUS NEITHER TO HIMSELF NOR TO OTHERS, HAD A RIGHT TO BE RESTORED TO LIBERTY EITHER BY TREATMENT OF ELSE BY RELEASE

As this Court observed in *Jackson* v. *Indiana*, 406 U.S. 715, 737-38 (1972):

> "The States have traditionally exercised broad power to commit persons found to be mentally ill. . . . Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." (Citations omitted.)

The central question in this case involves just such a limitation: did respondent, a mental patient who was involuntarily confined for 15 years in Florida State Hospital and who was dangerous neither to himself nor to others, have a substantive constitutional right to be restored to liberty either by treatment or else by release. This question, as it arises here, is a narrow but important one.

It is important because those mentally ill persons subjected to the states' involuntary, civil commitment processes, are one of the most vulnerable segments of society—usually destitute, often without families, and generally powerless to resist the arbitrary exercise of state authority affecting their most basic personal liberties.[22] The mentally ill are particularly vulnerable *after*

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[22] *See generally*, American Bar Foundation, The Mentally Disabled and the Law 1-14 (S. Brakel and R. Rock, eds.) (rev. ed. 1971) (hereinafter "ABF Study"); D. Rothman, Discovery of the

they have been involuntarily hospitalzed by court order, since, historically, both case and statutory law have focused primarily on commitment procedures rather than on post-confinement rights.[23] To safeguard the constitutional rights of mental patients courts must scrutinize the conditions of involuntary confinement.[24] The most

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Asylum (1971); R. Rock, M. Jacobson and J. Janopaul, Hospitalization and Discharge of the Mentally Ill (1968); E. Goffman, Asylums (1961); Joint Commission on Mental Illness and Health, Action for Mental Health (1961); A. Deutsch, The Mentally Ill in America (2d ed. 1949).

See also, Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constit. Rights of the Senate Comm. on the Judiciary, 87th Cong., 1st Sess., 1 (1961) (hereinafter, the "1961 Hearings"); *Hearings on The Constitutional Rights of the Mentally Ill Before the Subcomm. on Consit. Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st and 2d Sess. (1969-70) (hereinafter, "1970 Hearings").

[23] "Recognizing that commitment of the mentally ill is a serious deprivation of liberty, the law has encouraged the use of procedural safeguards . . . for commitment proceedings. However, there has been little corresponding consideration of an inmate's rights after commitment." Note, *The Nascent Right to Treatment*, 53 Va. L. Rev. 1134, 1135 (1967) (hereinafter, "Virginia Note"), citing A. Deutsch, note 22, *supra* and M. Guttmacher & H. Weihoffen, Psychiatry and the Law (1952). *See also*, ABF Study, *supra*, note 22, at 171 ("Statutes by and large do not adequately protect the rights of patients who have been hospitalized."); 1961 Hearings, *supra*, note 22, at 1 (remarks of Sen. Ervin: "the constitutional rights of hundreds of thousands of patients" after they are confined under governmental control "are of much greater significance" than the rights which attach before confinement during "hospitalization procedures."); Mental Health Law Project and Practicing Law Institute, Legal Rights of the Mentally Handicapped 275 (B. Ennis & P. Friedman eds. 1973).

[24] Conditions in large state mental hospitals have historically been inadequate at best. *Jackson* v. *Indiana*, 406 U.S. 715, 734-35, n.17 (1972). There "are substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *Id. See also*, ABF Study, *supra*, note 22, at 417-18. *See generally*, A. Deutsch, *supra*, note 22; A. Deutsch, The Shame of the States (1948); Joint Commission on Mental Illness and Health, *supra*, note 22; Solomon, *The*

critical of the post-confinement rights—the right to be restored to liberty either by treatment or else by release—has been recognized and endorsed by medical experts,[25] by legal commentators,[26] and by the United

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American Psychiatric Association in Relation to American Psychiatry, 115 Am. J. Psychiatry 1 (1958); Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Fifteen Indices: An Aid in Reviewing State and Local Mental Health Programs 6 (1966); American Psychiatric Association Task Force on the Right to Care and Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded 1 (4th Draft, Oct. 1974).

[25] *See, e.g., amici curiae* briefs in support of the constitutional right to treatment or release filed in the instant case by American Psychological Association, American Psychiatric Association, American Orthopsychiatric Association and National Association for Mental Health. *See also*, American Psychiatric Association Task Force on the Right to Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded 1 (4th Draft, Oct. 1974) ("The American Psychiatric Association, whose membership has always *implicitly* recognized and worked to implement the right to adequate care and treatment, now joins and endorses efforts towards this goal by stating its *explicit* support of this right.") (Emphasis in original.)

[26] The constitutional right to treatment or release for involuntarily committed mental patients has "received an unusual amount of scholarly discussion and support." *Donaldson* v. *O'Connor*, 493 F.2d 507 (5th Cir. 1974). The first articulation of the right is found in Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). In the last 15 years more than 30 law review articles have been published on the subject, virtually all of them supporting a constitutional right to treatment or release for the involuntarily confined. *See, e.g.*, Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190 (1974) (hereinafter "*Developments—Civil Commitment*"); Note, *Rights of the Mentally Ill During Incarceration—the Developing Law*, 25 U. Fla. L. Rev. 494 (1973); Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282 (1973) (hereinafter "*Wyatt* Comment"); Robitscher, *Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 Vill. L. Rev. 11 (1972); Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Lawyer 951 (1972); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Con-*

States.[27] Most importantly, there exists "an enormous range of precedent" supporting such a right, *Donaldson* v. *O'Connor*, 493 F.2d 507, 519-20 (5th Cir. 1974.) [28]

stitutional Imperatives, 70 Mich. L. Rev. 1108 (1972); Goodman, *Right to Treatment: The Responsibility of the Courts*, 57 Georgetown L. J. 680 (1969); Katz, *The Right to Treatment—An Enchanting Legal Fiction*, 36 U. Chi. L. Rev. 755 (1969); Virginia Note, *supra*, note 23; Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 Yale L. J. 87 (1967); Drake, *Enforcing The Right To Treatment*, 10 Am. Crim. L. Rev. 587 (1972).

[27] The United States has participated in many of the important right to treatment cases. In *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974), the United States stated that its interest as *amicus curiae* was to attack the "widespread and severe deprivation of the constitutional rights of citizens" who are civilly committed and urged the court to recognize that involuntarily confined mental patients "have a constitutional right to receive such treatment . . . as will give them a realistic opportunity to be cured or to improve their condition." Brief of *Amicus Curiae* United States, at 9. Early in 1974, the Justice Department filed suit in the name of the United States against Rosewood State Hospital in Maryland, alleging, *inter alia*, that the state had deprived civilly committed patients of their constitutional right to treatment. *United States* v. *Solomon, et al.*, Civ. Act. No. 74-181 (D. Md., filed Feb. 21, 1974). The United States has also participated as *amicus* with the rights of a party in another suit seeking a right to treatment or habilitation for the mentally retarded. *New York Ass'n for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973).

[28] The constitutional right to treatment or release for the mentally ill and the mentally retarded has been recognized by both federal and state courts. *See, e.g., Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) and 344 F. Supp. 387, 390 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974) (class actions on behalf of the mentally ill and the mentally retarded); *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) (class action involving the mentally retarded); *Davis, et al.* v. *Watkins, et al.*, No. C 73-205, slip opinion at 1-2 (N.D. Ohio, Sept. 1974) (interim order) (class action on behalf of the mentally ill); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *Kesselbrenner* v. *Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973); *Renelli* v. *Dept. of Mental Hygiene*, 340 N.Y.S.2d 498, —— N.E.2d —— (1973).

There is also a widening body of precedent holding that there is a constitutional right to treatment for persons committed under "non-penal" statutes for the purpose of care and treatment: (a)

The right to be restored to liberty either by treatment or else by release is a right that has been recognized in many different factual contexts, each with varying legal issues and societal interests. But in order to resolve the issues raised by the facts and jury instructions of this case, this Court need not resolve issues that have been (or might be) raised by other, quite different "right to treatment" cases. Here, a harmless mental patient who was confined for the express purpose of treatment sought damages for the failure of state officials to release him when they knew he was not re-

juvenile delinquents, *Nelson* v. *Heyne*, 355 F. Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352, 360 (7th Cir. 1974), *cert. denied*, —— U.S. ——; *Inmates of Boys Training School* v. *Affleck*, 346 F. Supp. 1354, 1364 (D. R.I. 1972); *Morales* v. *Turman*, 364 F. Supp. 166, 175 (E.D. Tex. 1973); (b) *"persons in need of supervision," Martarella* v. *Kelley*, 349 F. Supp. 575, 585, 598-600 (S.D. N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973); *M* v. *M*, 336 N.Y.S.2d 304, 71 Misc.2d 396 (Fam. Ct. 1970); *In re J*, 316 N.Y.S.2d 356 (Fam. Ct. 1970); (c) *sexual offenders and defective delinquents*, *Stachulak* v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Davy* v. *Sullivan*, 354 F. Supp. 1320, 1328-1329 (M.D. Md. 1973) (three judge court); *Gomes* v. *Gaughn*, 471 F.2d 794, 800 (1st Cir. 1973); *Sas* v. *Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. denied*, 407 U.S. 355 (1972); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958); *Commonwealth* v. *Page*, 339 Mass. 313, 159 N.E.2d 82 (1959); *Director of Patuxent Institution* v. *Daniels*, 243 Md. 16, 221 A.2d 397 (1966); *Silvers* v. *People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970); and (d) *persons incompetent to stand trial*, *United States* v. *Walker*, 335 F. Supp. 705, 708 (N.D. Cal. 1971); *United States* v. *Pardue*, 354 F. Supp. 1377, 1382 (D. Conn. 1973); *Nason* v. *Superintendent of Bridgewater State Hospital*, 253 Mass. 604, 612-613, 233 N.E.2d 908, 913-14 (1968); *Maatallah* v. *Warden, Nevada State Prison*, 86 Nev. 430, 420 P.2d 122 (1970)).

The right to treatment was rejected by the District Court in *Burnham* v. *Department of Public Health*, 349 F. Supp. 1335 (N.D. Ga. 1972), *reversed and remanded*, No. 72-3110 (5th Cir. Nov. 8, 1974). In *N.Y. State Ass'n for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the District Court did not recognize the right to treatment when deciding whether to grant a preliminary injunction but subsequently reserved decision on the issue pending presentation of evidence and further briefing. No. 72 Civ. 356, 357, Order of May 23, 1974, at 2.

ceiving treatment. Accordingly, in order to affirm the holding of the Court of Appeals, this Court need *not* decide:

1. Whether an involuntarily confined mental patient who is dangerous, either to self or to others, has a right to be treated or to be released;[29]
2. Whether civil commitment of the mentally ill for any purpose other than treatment is constitutionally permissible;
3. Whether the provision of treatment can itself justify the indeterminate or long-term confinement of mentally ill persons who are dangerous neither to self nor to others;
4. Whether courts can determine if the level of treatment received is "reasonable," in a constitutional sense, when, in contrast to this case, a patient receives more than the custodial care available in a prison;

[29] As will be discussed at pp. 58-59, *infra*, the Court of Appeals rested its decision on alternative holdings. The narrower one, which applies to the mentally ill who are dangerous neither to self nor to others, controls respondent's case. But respondent respectfully submits that the Court of Appeals' alternative holding, which applies to all involuntarily confined mental patients, was equally valid, *see* note 61, *infra*.

In any event, it should be emphasized that vast numbers of patients involuntarily confined in large mental institutions are not dangerous to self or to others. *See generally*, *Wyatt* Comment, *supra*, note 26, at 1289, n.43 (citing studies indicating that approximately 90% of patients involuntarily confined are not sufficiently dangerous to themselves or to others to require hospitalization). A 1970 study by the National Institute of Mental Health of the patient population at Saint Elizabeths Hospital in the District of Columbia revealed that nearly 70% of the patients confined therein did not have behavior problems and consequently could be discharged or released to such facilities as foster homes or half-way houses. National Center for Mental Health Services, Training and Research of NIMH, NCM-SEH Patient Inventory (1970).

5. Whether courts can establish institution-wide standards for ensuring the provision of treatment that is "reasonable" in a constitutional sense?[30]

Moreover, the impact of affirmance on Florida's mental health system will be negligible since, within the past two years, Florida has substantially altered its civil commitment law and has provided both a statutory right to treatment and a cause of action in damages against state doctors who abridge that right.[31]

The narrow "right to treatment" issue posed by this case is contained in the instructions to the jury. The oral charge, which will be discussed in greater detail below, was as follows:

> "In order to prove his claim under the Civil Rights Act, the burden is upon the Plaintiff in this case to establish by a preponderance of the evidence in this case the following facts:
>
> That the Defendants confined Plaintiff against his will, *knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness.*
>
> Second, that the Defendants then and there acted under the color of state law.
>
> Third, that the Defendants' acts and conduct deprived the Plaintiff of his Federal Constitutional right not to be denied or deprived of his liberty without due process of law as that phrase is defined

[30] The instant case is, therefore, to be distinguished from *Wyatt* v. *Aderholt*, *supra*, note 28, and from *Burnham* v. *Department of Public Health*, *supra*, note 28. Both *Wyatt* and *Burnham*, upon which petitioner relies, were class actions seeking declaratory and injunctive relief and the establishment of constitutionally required minimum standards governing conditions in state mental hospitals for the involuntarily confined.

[31] *See* pp. 70-71, 84-85, and notes 79 and 99, *infra*.

and explained in these instructions, and fourth, that the Defendants' acts and conduct were the proximate cause of his injury and consequent damages that he suffered. . . .

You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a *constitutional right to receive such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.*

Now, *the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others.* Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that the Plaintiff was dangerous either to himself or others." A at 183, 186.[32] (Emphasis added.)

In this section, respondent will demonstrate that these instructions were a correct statement of the applicable constitutional law. Although this Court has infrequently considered the rights of involuntarily confined mental patients, its concern for their constitutional rights is not new. The Court of Appeals' acknowledgement of respondent's post-commitment right to restoration of liberty by treatment or else by release, in the circumstances of this case, was consistent with the sensitive admonition of this Court issued nearly a quarter of a century ago:

> "We fully recognize the *danger of a deprivation of due process* in proceedings dealing with persons charged with insanity . . . and the *special importance of maintaining the basic interests of liberty* in a class of cases where the law though 'fair on its face and impartial in appearance' may be open to *serious abuses in administration* and courts may be imposed upon if the *substantial rights* of the persons charged are not adequately safeguarded at *every stage* of the proceedings."

Minnesota ex rel. Pearson v. *Probate Court*, 309 U.S. 270, 276-77 (1940). (Emphasis added.)

[32] This oral charge given to the jury was discussed in slightly different form in chambers as Plaintiff's Proposed Instructions #34, #37, and #38.

A. Respondent's Involuntary Civil Commitment Abridged His Constitutionally Protected Liberty

Recognition of respondent's right to treatment or release begins with the elementary principle that the civil commitment of the mentally ill infringes constitutionally protected liberty. In 1957, respondent was judged mentally incompetent, and was involuntarily and *indefinitely* committed to the Florida State Hospital at Chattahoochee under non-criminal standards and procedures. Not only did this commitment expressly impose civil disabilities by statute,[33] but, by placing him under the total control of state hospital authorities, it abridged the most basic aspect of constitutional liberty—the right to be free from physical confinement. *Arnett* v. *Kennedy*, 94 S.Ct. 1633, 1646 (1974) (core meaning of constitutional liberty is "the elemental freedom from external restraint."). Moreover, respondent's lengthy confinement as mentally ill infringed his due process right to be free from unwar-

[33] Title 27 Florida Statutes § 394.22(10) (Laws 1945, Ch. 23157 § 3) (repealed July 1, 1972) provided that

> After a judgment adjudicating a person to be mentally incompetent is filed in the office of the county judge, such person shall be presumed to be incapable, for the duration of such incompetence, of managing his own affairs or of making any gift, contract, or any instrument in writing which is binding on him or his estate.

For a discussion of the civil disabilities expressly imposed by civil commitment statutes, *see generally*, ABF Study, *supra*, note 22 at 155-341; *Developments—Civil Commitment*, *supra*, note 26, at 1198-1200.

ranted stigma.[34] Further, long-term confinement in mental institutions which provide only custodial care, if that, often causes deterioration, not improvement, in patients' mental conditions, leading to additional deprivations of liberty.[35] Finally, involuntary confinement abridges other basic constitutional rights.[36]

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[34] Stigmatization constitutes a deprivation of constitutionally protected liberty, *Board of Regents* v. *Roth*, 408 U.S. 564, 573 (1972). A "former mental patient may suffer from social opprobrium which attaches to treatment for mental illness and which may have more severe consequences than do . . . formally imposed disabilities. . . . The legal and social consequences of commitment constitute the stigma of mental illness, a stigma that could be as socially debilitating as that of a criminal conviction," *Developments—Civil Commitment*, *supra*, note 26, at 1200-01 (and cases cited therein). "Civil commitment involves stigmatizing the affected individuals, and the stigma attached, though in theory less severe than the stigma attached to criminal conviction, may in reality be as severe, *or more so*." *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520 (Emphasis added.)

[35] The deterioration of patients' intellectual, social and physical functioning *as a result* of custodial confinement in large understaffed and overcrowded mental hospitals has been widely recognized in the medical and social science literature. The popular name for this phenomenon of deterioration is "institutionalization." *See, e.g.*, E. Goffman, Asylums (1961); R. Barton, Institutional Neurosis (1966); Gruenberg, *The Social Breakdown Syndrone —Some Origins*, 123 Am. J. Psychiatry 12 (1967); I. Belknap, Human Problems of State Mental Hospitals (1956); M. Schwartz & Schwartz, Social Approaches to Mental Patient Care (1964); J. Wing & G. Brown, Institutionalization and Schizophrenia (1970). *See also* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1108, 1126-29 (1972); 1961 Hearings, *supra*, note 22, at 18, 43-44, 124, 637.

One of respondent's expert witnesses, Dr. Walter Fox, testified that respondent's lack of deterioration showed that respondent was uniquely independent: ". . . Mr. Donaldson had . . . more . . . internal strength than most of the people that would find themselves in that sort of total institution for that period of time." A 6; T 11/21/72 at 71.

[36] Involuntary confinement severely limits the exercise of other constitutional rights such as the right to privacy and personal autonomy, *Roe* v. *Wade*, 410 U.S. 113 (1973); the right to asociation, *Shelton* v. *Tucker*, 364 U.S. 479 (1960); the right to travel, *Shapiro* v. *Thompson*, 394 U.S. 618 (1969); the "right to work for a living in the common occupations of the community", *Truax* v. *Raich*, 239 U.S. 33 (1915); and the right to movement, *Papachristou* v. *City of Jacksonville*, 405 U.S. 156 (1972).

This Court has recognized that involuntary confinement of persons on the ground of mental illness affects "fundamental rights", *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966), and entails a "massive curtailment of liberty" in a constitutional sense, *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Avoiding such extreme restrictions on liberty is an interest of "transcending value," *In re Winship*, 397 U.S. 358, 364 (1970). As Judge Wisdom noted below:

> "*The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary.* Indeed, civil commitment, because it is for an indefinite term, may in some ways involve a more serious abridgement of personal freedom than imprisonment for commission of a crime usually does . . . . *Since civil commitment involves deprivations of liberty of the kind with which the due process clause is frequently concerned, that clause has the major role in regulating government actions in this area.*"

Donaldson v. *O'Connor*, *supra*, 493 F.2d at 520. (Emphasis added; citations omitted.) And, as Judge Tamm has stated, "There can no longer be any doubt that the nature of the interests involved when a person . . . [is] involuntarily committed . . . is 'one within the contemplation of the "liberty and property" language of the Fourteenth Amendment.'" *In re Ballay*, 482 F.2d 648, 655 (D.C. Cir. 1973), quoting *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972).

Respondent, though he had committed no crime, was deprived of liberty for 175 months, or nearly 15 years.

That compares with an average time served for federal convicts of only 17.7 months.[37] Persons convicted of homicide or rape on federal property serve, on the average 80.1 and 38.4 months, respectively.[38] In short, the deprivation of physical liberty involved in this case was much longer than that which society ordinarily deems justified even for the most serious crimes.

B. The Stated Purpose of Respondent's Involuntary Confinement Was To Provide Him With Treatment for His Mental Illness in Order To Return Him to the Community

If liberties cognizable under the Due Process Clause have been abridged by state action, then there are two basic methods for challenging the validity of the abridgment. First, the aggrieved party may question whether the abridgement can be justified in terms of a permissible governmental goal. *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738; *Roe* v. *Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting); *Vlandis* v. *Kline*, 412 U.S. 441 (1973); *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 491 (1955); *Nebbia* v. *New York*, 291 U.S. 502, 525 (1934); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-400 (1923). *Cf. James* v. *Strange*, 407 U.S. 128 (1972); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972).[39] Second, the aggrieved party may refrain from litigating the permissibility of the stated purpose, and simply question whether there is a rational relationship between the stated purpose of

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[37] Federal Bureau of Prisons, Statistical Reports, Fiscal Year 1973, Table C-2, at 97-98.

[38] Federal Bureau of Prisons, Statistical Reports, Fiscal Year 1973, Table C-2, at 97-98.

[39] *See generally* Tribe, *Foreward: Toward a Model of Roles in the Due Process of Life Law*, 86 Harv. L. Rev. 1, 17 (1973). Cf. Gunther, *Foreward: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection*, 86 Harv. L. Rev. 1, 17-20 (1972).

the abridgement and the means for effecting that purpose. *Nebbia* v. *New York*, *supra*; *Meyer* v. *Nebraska*, *supra*; *Vlandis* v. *Kline*, *supra*; *Jackson* v. *Indiana*, *supra*.

Only this second approach was employed by respondent. Specifically, respondent neither challenged nor conceded the constitutional permissibility of abridging his constitutional right to liberty for the purpose of treatment. Instead, respondent proved at trial that there was no rational relation between the stated purpose of his confinement—treatment for mental illness in order to restore him to liberty—and the actual nature of that confinement.

1. *As petitioner knew, the stated purpose of respondent's confinement was to provide treatment so that respondent would be returned to the community.*

As has been noted above, *see* pp. 3-5, *supra*, the statute authorizing respondent's civil commitment expressly stated that involuntary confinement was "for the purpose of care, custody *and treatment*." Title 27 Florida Statutes 394.09 (1941) (Laws 1877, Ch. 3036 § 1) (repealed July 1, 1972). (Emphasis added.) Moreover, the judicial order delivering respondent to the state hospital expressly stated that respondent was committed "to the Superintendent of Florida State Hospital, Chattahoochee, Florida, for care, maintenance *and treatment*." Plaintiff's Exhibit 13, "Order for Delivery of Mentally Incompetent." (Emphasis added.) Both the statutory provision and the order were clear on their face that respondent was to receive more than mere custodial care. Because the phrases "care, custody and treatment" and "care, maintenance and treatment" are conjunctive in form, it follows that treatment was a necessary purpose of respondent's confinement. Moreover, as has also

been noted, *see* p. 4, *supra*, this purpose is reflected in the By-Laws, Rules and Regulations of the Medical Staff of Florida State Hospital, which were promulgated by petitioner during respondent's confinement. Those by-laws expressly state that the Florida State Hospital was "established to provide a *treatment facility* for the mentally ill", and state further: "Our *primary objective* is to return the patients as useful citizens, to their own community, as soon as possible. The mental hospital should only be an intermediate step in the *treatment and rehabilitation* of the patient." *See* p. 4, *supra*. (Emphasis added.)[40]

Thus express statute, order and regulation made clear that respondent was confined for the purpose of treatment. Moreover, the jury could have found, as fact, that

[40] There is increasing recognition that restoring the liberty of the mentally ill by returning the mentally ill to a productive normal life as soon as possible and insofar as possible should be the overarching objective of all civil commitment. Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A. J. 1371, 1371 (1974): "The major trend in mental health . . . is de-institutionalization. . . . The hypothesis of this trend is rehabilitation rather than incarceration. . . . The major provisons of the legislation and case law governing the commitment, admission, hospitalization and discharge of the mentally ill and retarded speak to maximizing the patient's opportunities to stay out, to get out, and while in to get the most advantages with the minimum of suffering." *See also* 1961 Hearings, note 22, *supra*, at 224 (Remarks of Sen. Ervin: ". . . the primary object of commitment is to treat people and restore them to society as soon as it is determined that they have the capacity to readjust themselves."); ABF Study, supra, note 22, at 39 ("primary mission" of state mental hospitals is "treatment of mental illness."); American Psychiatric Association, Standards for Psychiatric Facilities 2 (1969) ("The primary functions of any psychiatric facility are to diagnose, to treat and to restore mentally disordered persons to an optimal level of functioning, and return to the community.").

It would, therefore, be more analytically correct for courts and commentators to say that "treatment" is not a "purpose", but rather a "means" of effecting the only constitutionally permissible purpose of civil commitment, namely, the restoration of a mentally ill person's liberty and his return to the community.

petitioner knew that respondent was confined for the purpose of providing treatment that would restore respondent to the community.[41]

2. *Custodial care of a mentally ill person who is neither dangerous to himself nor to others is not a constitutionally permissible purpose for involuntary confinement.*

Petitioner asserts here for the first time that custodial care, *without more*, is a permissible purpose for involuntary confinement of the harmless mentally ill. Petr. Brief at 41-42. In making this assertion, petitioner simply ignores the state statutes, judicial order and Hospital Regulations in effect during respondent's confinement. These indicate that, although custodial care was a necessary purpose of confinement, it was not a necessary *and* sufficient purpose under state law, *i.e.*, it could not, by itself, justify involuntary confinement. Moreover, petitioner did not argue that custodial care alone justified confinement of a non-dangerous mental patient nor did he proposed a jury instruction to that effect.[42] Accord-

[41] The *By-Laws, Rules and Regulations of the Medical Staff of Florida State Hospital* promulgated by petitioner were introduced into evidence as Plaintiff's Exhibit #2. Petitioner also conceded that the purpose of confining respondent was to ensure that respondent could "make [an] adjustment" outside the hospital. A 130; T 11/28/72 at 86.

[42] To the contrary, petitioner did not object to the first sentence of Plaintiff's Proposed Instruction No. 38, which provided, as revised in chambers by the trial judge, that "the purpose of involuntary hospitalization is treatment, and not mere custodial care or punishment if a patient is not a danger to himself or others." T 11/28/72 at 8-9. In a pre-trial brief, petitioner had objected to that instruction as a whole, but only because of the second sentence, which provided "Without such treatment there is no justification, from a constitutional stand-point, for continued confinement." Petitioner *agreed* that confinement of non-dangerous persons without treatment was not justified, but proposed to limit the means by which such unjustifiably confined patients could secure release to

ingly, this issue is not properly before this Court.[43]

If, however, this Court chooses to reach the issue, it should decide that, for a mentally ill person, who is dangerous neither to himself nor to others, the provision of mere custodial care, which a person would receive in a prison, cannot justify the massive deprivation of liberty involuntary confinement entails.

Historically, states have justified civil commitment of the mentally ill according to two broad *purposes*: rehabilitation of the mentally ill individual pursuant to the state's beneficent *parens patriae* power or protection of society from dangerous persons pursuant to the state's police power. *See generally*, Note, *Civil Commitment of the Mentally Ill: Theories & Procedures*, 70 Harv. L. Rev. 1288 (1966); Note, *The Nascent Right to Treatment*, 53 Va. L. Rev. 1134, 1138-39 (1967) (hereinafter "Virginia Note"); Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1207-1240 (1974) (hereinafter *"Developments—Civil Commitment"*).[44]

Under these broad *parens patriae* or police powers, states have traditionally sought involuntary commitment

"judicial process," thereby excusing petitioner from liability for failure or refusal to exercise his authority to effect an administrative release. 493 F.2d at 518-19, n.8.

[43] *See* note 92, *infra*.

[44] The state's *parens patriae* power, which originally lodged in the King and now resides in the legislature, *Hawaii* v. *Standard Oil Co.*, 405 U.S. 251, 257 (1972), is "inherent in the supreme power of every state." *Mormon Church* v. *United States*, 136 U.S. 1, 57 (1890). The core of the concept is that the state acts as "guardian" of citizens with disabilities. *Hawaii* v. *Standard Oil Co.*, *supra*, 405 U.S. at 257. The power serves as the basis for state laws which protect minors, establish guardianships, and provide for the involuntary commitment of the mentally ill. *See generally, Developments—Civil Commitment, supra*, note 26, at 1207-10 (nature and origins of power).

of the mentally ill according to one of three *standards*: when mental illness results in (a) danger to others; (b) danger to self; or (c) the need for treatment. *Jackson* v. *Indiana*, *supra*, 406 U.S. at 737, n.19; American Bar Foundation, The Mentally Disabled and the Law 37-49 (S. Brakel & R. Rock eds.) (rev. ed. 1971) (hereinafter, "ABF Study") (summarizing the laws of the states as of 1971); *Developments—Civil Commitment*, *supra*, at 1203-4 (summarizing the laws of the states as of 1974).[45]

When the state civilly commits or continues to confine a mentally ill individual who is dangerous neither to himself nor to others, it is acting pursuant to its *parens patriae* power and the purpose of exercising that power is to promote the interests of the individual. *Id.*, at 1222; ABF Study, *supra*, at 34-40.[46] In such circumstances, civil commitment cannot be justified as an exercise of the police power for the protection of society. Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A. J. 1371 (1974).[47]

[45] The precise relationships between the broad *parens patriae* or police power goals which *justify* commitment and the statutory criteria which *trigger* commitment are "seldom spelled out" by state legislatures. Virginia Note, *supra*, note 26, at 1138. And the absence of litigation focusing on the legality of commitment standards has "left the boundaries of the state's commitment power largely undefined," *Developments—Civil Commitment*, *supra*, note 26, at 1207; *Jackson* v. *Indiana*, *supra*, 406 U.S. at 737-38.

[46] *See also*, Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv. L. Rev. 1288, 1289, n.11 (1966) ("Unless proceedings against a person have met the standards for a dangerousness commitment, a hospital should only consider *his best interests* in treating him.") (Emphasis added); Virginia Note, *supra*, note 23, at 1138-39 (police power commitments look to dangerousness and protection of society not to the best interests of the individual).

[47] In *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520-21, Judge Wisdom noted that it "is analytically useful to conceive of these grounds as falling into two categories, one consisting of 'police power' rationales for confinement, the other of '*parens patriae*'

Under the instructions in this case, respondent bore the burden of proving that there was and could have been no police power rationale for his confinement. The judge instructed the jury that "the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others," A. 186, and the instructions required respondent to prove that petitioner confined respondent "knowing that he was not . . . dangerous." Accordingly, under the instructions in this case, the right to treatment or release was limited to persons civilly confined exclusively under the *parens patriae* power,[48] not under the police power.[49]

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rationales . . . [The] need for care or treatment [is] a '*parens patriae*' rationale."

[48] The court below expressly viewed the purpose of respondent's continued confinement as exclusively a *parens patriae* purpose, 493 F.2d at 521.

[49] There was ample evidence before the jury to support a finding of non-dangerousness, *see* pp. 14-18, *supra*. Under applicable principles of appellate review it would be inappropriate for this Court to evaluate the sufficiency of the evidence or to reach a different assessment of the facts. Petitioner attempts to establish here that respondent was dangerous to self or to others, Petr. Brief at 9, 18, and to argue this case as if respondent were. *Id.* at 18-19. But petitioner offers no principles and cites no precedent which would justify upsetting the jury's finding. This is not surprising since the great weight of authority is against petitioner.

In reviewing a jury verdict, the appellate court "takes that view of the evidence that is most favorable to the appellee, that it assumes all conflicts in the evidence were resolved in his favor, and that he must be given the benefit of all favorable inferences." 9 Wright and Miller, Federal Practice and Procedure § 2585 at 730 (1971). *See also* 5A J. Moore, Federal Practice ¶ 52.02 at 2611 (2d ed. 1974). This limited appellate review of a jury's factual determinations has been consistently employed by this Court. *See, e.g. Atlantic & Gulf Stevedores, Inc.* v. *Ellerman Lines, Ltd.*, 369 U.S. 355, 358-59 (1962). *See also, Southwestern Brewery & Ice. Co.* v. *Schmidt*, 266 U.S. 162, 169 (1912) (Holmes, J.: Whether "there was . . . credible evidence to sustain the verdict . . . was for the jury, not for this court."); *Eastman Kodak Co.*

The question raised here by petitioner for the first time, then, is whether a mentally ill but non-dangerous person can constitutionally be confined pursuant to the state's *parens patriae* power *solely* for the purpose of providing custodial care.

This Court has never directly ruled upon that question, but even in cases in which confinement can be justified, at least in part, under the police power, this Court has not hesitated to acknowledge that custodial confinement *without treatment* raises "substantial constitutional" questions. *McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 250 (1972). *See also, Murel* v. *Baltimore City Criminal Ct.*, 407 U.S. 355, 358 (1972); *In re Gault*, 387 U.S. 1, 22, n.30 (1967). Furthermore, this Court has strongly suggested, though never explicitly ruled, that even the provision of treatment may not be sufficient to justify the indeterminate or long-term confinement of a mentally ill person who is dangerous neither to self nor to others. *Greenwood* v. *United States*, 350 U.S. 366 (1956); *Jackson* v. *Indiana*, 406 U.S. 715 (1972); *Humphrey* v. *Cady*, 405 U.S. 504 (1972).[50] If, as *Greenwood*, *Jackson* and *Humphrey*

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v. *Southern Photo Materials Co.*, 273 U.S. 359, 375 (1927); *Lumberman's Mutual Casualty Co.* v. *Elbert*, 348 U.S. 48, 53 n.5 (1954); *Zenith Radio Corp.* v. *Hazeltime Research, Inc.*, 395 U.S. 100, 123 (1969).

This Court has repeatedly recognized the principle that taking a case from the jury by granting a directed verdict is permissible only in very limited circumstances. *See, Continental Ore Co.* v. *Union Carbide & Carbon Corp.*, 370 U.S. 690, 696 (1962); *Galloway* v. *United States*, 319 U.S. 372, 395 (1943); *Gunning* v. *Cooley*, 281 U.S. 90, 93 (1930); *Brady* v. *Southern Ry. Co.*, 320 U.S. 476, 479 (1943). *See generally*, 9 Wright and Miller, Federal Practice and Procedure § 2524 at 543-546; 5A J. Moore, Federal Practice, ¶ 50.02[1] at 2326-2327 (2d ed. 1974).

[50] In *Greenwood* v. *United States*, 350 U.S. 366 (1956), for example, this Court indicated that long-term hospitalization could constitutionally be justified only upon a finding of mental incompetence *and* dangerousness. In *Jackson* v. *Indiana*, 406 U.S. 715

suggest, long-term confinement of non-dangerous mentally ill persons *for treatment* is constitutionally suspect, it follows *a fortiorari* that long-term or indeterminate confinement of non-dangerous, mentally ill persons *for custodial care* is doubly suspect.

Virtually every court to consider the issue has ruled or indicated that long-term confinement of non-dangerous mental patients, solely for custodial care, is functionally indistinguishable from imprisonment for crime, and is therefore constitutionally impermissible. In *Robinson* v. *California*, 370 U.S. 660 (1962), as well as in subsequent cases, this Court has made clear that no one may constitutionally be punished for the mere "status" of being mentally ill, and that confinement of non-dangerous persons, in prison-like institutions,[51] without "treatment" would be viewed as punishment violative of the Eighth and Fourteenth Amendments.[52]

(1972), this Court cited a long list of federal decisions since *Greenwood*, all of which ruled "without exception" that "indefinite commitment on the grounds of incompetency alone," without proof of dangerousness, was impermissible. *Id.* at 731-34. Finally, in *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), this Court noted with approval that Wisconsin, like most states, conditioned confinement "for compulsory psychiatric treatment . . . not solely on the medical judgment that the defendant is mentally ill *and treatable*, but *also* on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty." (Emphasis added.)

[51] *Robinson* was concerned with confinement in a "prison." But constitutional rights depend on functional realities, not on the "civil" or "criminal" label which attaches to an instiution or procedure. *Specht* v. *Patterson*, 386 U.S. 605 (1967); *In re Gault*, 387 U.S. 1 (1967). Respondent's rights cannot be abridged merely by "the hanging of a new sign—reading 'hospital'—over one wing of the jailhouse." Powell v. Texas, 392 U.S. 514, 529 (1968). *See also*, Virginia Note, note 23, *supra*.

[52] In *Martarella* v. *Kelley*, 349 F. Supp. 575, 599 (S.D.N.Y. 1972), the District Court cited *Robinson* as authority for the following principle: ". . . although the State might legally detain non-

In sum, if it chooses to reach that issue, this Court should follow the suggestions contained in its own opinions and the rulings of the courts below and hold that the provision of mere custodial care, like that provided in a prison,[53] cannot justify the involuntary confinement of a mentally ill person who is dangerous neither to himself nor to others.[54]

criminals for compulsory treatment or other legitimate purposes which protect society or the person in custody, detention for mere illness—without a curative program—would be impermissable." *See also*, *Welsch* v. *Likins*, 373 F. Supp. 487, 496 (D.Minn. 1974); *United States* v. *Walker*, 335 F. Supp. 705, 708-09 (N.D. Cal. 1971); *United States* v. *Jackson*, 306 F. Supp. 4, 6 (N.D.Cal. 1971). Commentators cite *Robinson* for the same proposition: "confinement without treatment may be regarded as punishment for a mere condition—mental illness—over which the patient has no control, a punishment of the type declared unconstitutional in *Robinson* v. *California*." *Wyatt* Comment, note 26, *supra*, at 1292. Similarly, in the opinion below, the court noted that "absent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense," 493 F.2d at 522, n.22, quoting from *Wyatt* v. *Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971), subsequently *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 10, 1974), which in turn quoted from *Ragsdale* v. *Overholser*, 281 F.2d 943, 950 (D.C. Cir. 1960) (Fahy, J., concurring).

See also, note 56, *infra*, for a discussion of other theories which could be used in deciding that mere custodial care was not a permissible purpose of confinement in the circumstances of this case.

[53] Furthermore, even if the mere provision of custodial care could conceivably be, in some extreme circumstances, a constitutionally permissible purpose for the involuntary confinement of the mentally ill—which respondent does not concede—such extreme circumstances were not present in this case. For example, there was no basis for a reasonable belief that respondent was in a coma, was totally paralyzed or was simply incapable of providing even custodial care for himself. *See* pp. 19-21, *supra*. Accordingly, confinement for the purpose of custodial care could not be a constitutionally permissible purpose in this case, even if it could be in others.

[54] Petitioner incorrectly asserts that "the historical basis for the existence of state mental institutions was to safeguard the

3. *This Court should not hold that provision of treatment justifies involuntary confinement of a harmless mental patient.*

Although respondent has shown that the stated purpose advanced by Florida to justify his indeterminate and involuntary confinement was the provision of treatment, respondent respectfully urges this Court not to hold that treatment is a constitutionally permissible purpose for the confinement of a harmless mental patient. As has been noted, respondent neither challenged nor conceded the permissibility of the stated purpose used to justify his confinement, choosing instead to prove the absence of a rational relationship between that purpose and the nature of his confinement. Thus, the constitutional permissibility of that treatment purpose is not before this Court and *need not* be decided. The complex question whether treatment justifies the indeterminate and involuntary confinement of a non-dangerous mental patient *should not* be decided without full briefing based upon a complete record.[55] But if this Court chooses to reach this

individual and society, and to relieve the family of the financial and physical burden of caring for the mentally ill." Petr. Brief at 42. Nor is it true, as petitioner asserts, that "treatment as a goal of confinement of the mentally ill person," did not emerge until the "first half of this century." *Id.*, at 24. *See generally*, ABF Study, *supra*, note 22, at 7-8, 34; D. Rothman, The Discovery of the Asylum 130-38 (1971).

[55] In deciding whether a state could involuntarily and indeterminately confine a non-dangerous but mentally ill individual on the basis of that individual's need for treatment, this Court would have to confront the following issues, which were not briefed or argued below: is the right infringed by the commitment "fundamental;" is the justification—need for treatment—a "compelling state interest;" is the need-for-treatment standard governing confinement impermissibly vague; does the nature of the civilly committed individual's liberty interest require that no commitment can be for an indeterminate period; is involuntary confinement in a state mental hospital the least restrictive method for accomplishing a putatively permissible state purpose?

[Footnote continued on page 55]

issue it should hold that provision of treatment is *not* an adequate justification for involuntarily confining a mental patient who is dangerous neither to himself nor to others.[56]

[55] [Continued]

Increasingly, modern civil commitment laws have abandoned commitments based solely on the *criteria* of "in need of treatment" for, while treatment remains the primary *purpose* of commitment, there is a "trend toward restricting involuntary civil commitment to the dangerous mentally ill and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness," *Developments—Civil Commitment*, *supra*, note 26, at 1205. "The legal principles of modern commitment reform laws are intended . . . to remove the shackles of raw state power and to replace them with a more humane and sensitive balance forged from the Bill of Rights. *Our return to the standard of dangerousness has not been prompted by an interest in protecting the community from the dangerously insane but rather in protecting the mentally ill person from being involuntarily committed merely because a physician certifies that that person is mentally ill and in need of treatment.*" Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A.J. 1371, 1372 (1974). (Emphasis added.) There is, further, a strong trend in modern civil commitment laws toward encouraging voluntary rather than involuntary confinement of the mentally ill. *See, e.g.*, ABF Study, *supra*, note 22, at 17-33; Wexler, *Mental Health Law and the Movement Toward Voluntary Treatment*, 62 Calif. L. Rev. 671 (1974).

[56] In brief, respondent submits that his right to be free from physical restraint was a "fundamental" due process right. *Roe* v. *Wade*, *supra*, 410 U.S. at 168-70 (Stewart, J., concurring). Alternatively, respondent's right to privacy, *Roe* v. *Wade*, *supra*, 410 U.S. at 152-54, or his right to freedom of association, *Shelton* v. *Tucker*, 364 U.S. 479, 486 (1960), or his right to travel, *Shapiro* v. *Thompson*, 394 U.S. 618, 629-31 (1969), were all abridged by his involuntary confinement. These rights are also "fundamental." Accordingly, the state must have a "compelling interest" to justify involuntary confinement. When a patient is not dangerous to self or to others and when, therefore, the state involuntarily confines under its *parens patriae* power for the benefit of the individual, a general goal of "treatment", without further specification of the harms which treatment will prevent, will not justify the abrogation of fundamental constitutional rights entailed by involuntary confinement, any more than a generalized goal of "treatment" would justify incarceration for a physcial ailment if a person

C. Due Process Required That the Nature of Respondent's Involuntary Confinement Had To Be Reasonably Related to the Purpose of That Confinement: Respondent Thus Had a Constitutional Right to Treatment Or to Release

Due process requires that the governmental means of abridging a person's protected liberties, must, at the least, bear a rational relation to the purpose of such abridgement. *Nebbia* v. *New York*, *supra*; *Meyer* v. *Nebraska*, *supra*; *Vlandis* v. *Kline*, *supra*. In the context of confinement of the mentally disabled, the rule has been succinctly stated by this Court in *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738:

> "At the least, due process requires that the *nature* and duration *of commitment bear some reasonable relation to the purpose for which the individual is committed.*" (Emphasis added.)

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were not dangerous to self or to others. This Court has already suggested that long-term confinement of non-dangerous mentally ill patients is suspect, *see* p. 51 and note 50, *supra*. It is a long-standing rule of law in our society that there must be a knowing and voluntary consent before an individual may be given medical or psychiatric treatment. *See generally, Developments—Civil Commitment*, note 26, *supra*, at 1194-95. This basic tort principle—which may have constitutional dimensions—is abridged during involuntary confinement.

The argument presented immediately above applies *a fortiori* to demonstrate that the state may not confine a non-dangerous mental patient solely for custodial care. This argument thus complements the Eighth and Fourteenth Amendments argument on that point presented above. *See* p. 52, *supra*.

In *Lynch* v. *Baxley*, the District Court expressly said that it did not interpret the Court of Appeals' decision in this case to "raise the issue of the constitutional validity *ab initio* of the involuntary commitment of a nondangerous person for treatment or custodial purposes" or to "sanction the commitment of a nondangerous person against his will." Civ. Action No. 74-89-N (M.D. Ala. Dec. 14, 1974) (three-judge court).

Jackson involved the rights of a person charged with crime.[57] This case involves the rights of a non-dangerous mental patient who had not committed any anti-social act.[58]

Therefore, it follows *a fortiori* that during his involuntary confinement respondent had a right to be treated or to be released. As has been noted, the stated purpose and the only conceivable purpose of respondent's continued confinement was the restoration of his liberty through treatment. Thus, under *Jackson*, absent treatment, the nature of confinement bore no reasonable relation to the purpose of respondent's confinement, and continued confinement was therefore arbitrary state action in violation of the Due Process Clause of the Fourteenth Amendment. In the circumstances of this case, petitioner could have satisfied *Jackson's* elementary due process requirement either by treating or by releasing respondent.

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[57] *Jackson* involved a mentally defective deaf mute who was committed after the court determined that he was incompetent to stand trial for two petty robberies. Since the mental and physical defects which were the cause of his inability were not likely to improve during his confinement, and it was thus unlikely that he would ever become competent to stand trial, this Court ruled that the state could only detain him under its incompetency to stand trial provisions for a reasonable period to determine if improvement were possible. Otherwise, the state was required to proceed under civil commitment provisions if it sought to confine the defendant indefinitely.

[58] Even when confinement is not justified solely under the *parens patriae* power but also under the police power and the individual has committed a criminal act, this Court has suggested that involuntarily confined individuals have a right to treatment. *See McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 250 (1972); *Humphrey* v. *Cady*, 405 U.S. 504, 514 (1972) (indefinitely committed sex offender's allegation that he was receiving no treatment was a "substantial constitutional claim"); *Murel* v. *Baltimore City Criminal Ct.*, 407 U.S. 355, 357-58 (1972) (the commitment of a "defective delinquent" should be reviewed in terms of the "criteria, procedures and treatment provided").

The right to treatment for non-dangerous, involuntarily confined mental patients has been endorsed by nearly all commentators,[59] and has received near unanimous suppore in the case law.[60] As Judge Johnson held in one of the leading cases involving the rights of involuntarily confined mental patients, *Wyatt* v. *Stickney*, 325 F. Supp. 781, 785 (M.D. Ala. 1971), *aff'd sub nom.*, *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974):

> "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violates the very fundamentals of due process." [61]

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[59] *See, e.g.*, Virginia Note, *supra*, note 23, at 1137; *Developments—Civil Commitment*, *supra*, note 26, at 1324-29; *see generally*, articles cited at note 26, *supra*.

[60] *See, e.g.*, *Wyatt* v. *Stickney*, 325 F. Supp. 781, 784-85 (M.D. Ala. 1971) (mentally ill), 344 F. Supp. 387, 390 (M.D. Ala. 1972) (mentally retarded), *aff'd sub nom.*, *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974); *Welsch* v. *Likins*, 373 F. Supp. 487, 496-97 (D. Minn. 1974) (mentally retarded); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973) (mentally ill); *Martarella* v. *Kelley*, 349 F. Supp. 575, 585, 600 (S.D.N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973) ("persons in need of supervision"); *Davis, et al. v. Watkins, et al.*, No. C 73-205 (N.D. Ohio 1974). *Cf. Burnham* v. *Department of Public Health*, 349 F. Supp. 1335, 1340 n.10 (N.D. Ga. 1972), *reversed and remanded*, No. 72-3110 (5th Cir. Nov. 8, 1974). While petitioner generally relies on the District Court's opinion in *Burnham*, Petr. Brief at 29, 38, it appears that the court in that case rejected the right to treatment only for those committed pursuant to the police power, and did not decide the issue of whether such a right exists for individuals committed solely under the *parens patriae* rationale. Moreover, the decision in *Burnham* has not generally received support in subsequent decisions, *see, e.g.*, *Welsch* v. *Likins*, *supra*, 373 F. Supp. at 495. *See also*, *Wyatt* Comment, Note 26, *supra*, at 1284, n. 11 (detailed criticism of the District Court's opinion in *Burnham*).

[61] Respondent submits that even if he had been dangerous to self or to others he, like all involuntarily confined mental patients, would have had a right to treatment or to release.

[Footnote continued on page 59]

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[61] [Continued]

The right to treatment or to release for all involuntarily confined mental patients stems, first, from *due process* requirements. As Judge Wisdom stated:

> The second part of the theory of a due process right to treatment is based on the principle that when the three central limitations on the government's power to detain—that detention be in retribution for a specific offense; that it be limited to a fixed term; and that it be permitted after a proceeding where fundamental procedural safeguards are observed—are absent, there must be a *quid pro quo* extended by the government to justify confinement. And the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment. . . .

Donaldson v. *O'Connor*, *supra*, 493 F.2d at 522. In effect, the oft-used *quid pro quo* language is short-hand for the following reasoning: involuntary confinement abridges the fundamental due process right to be free from physical restraint; abridgement of this right may only be justified by a compelling state interest; the pure police power rationale of merely incarcertaing the mentally ill for the purpose of protecting society cannot justify indefinite incarceration of a mentally ill person who has committed no anti-social act and who has not been found "dangerous" pursuant to strict procedural due process safeguards; accordingly, even if an involuntary confined person is found dangerous by a committing court, confinement can only be justified by the police power purpose *plus* the *parens patriae* rationale of restoring the person to liberty through treatment; fundamental fairness requires no less; and if there is to be a constitutionally valid relationship between the compelling state interest and the nature of confinement, treatment must be provided or else the patient must be released.

Petitioner does not make any effort to rebut the *"quid pro quo"* reasoning nor does he attempt to distinguish away, or otherwise undercut, the broad range of precedent cited by the Court of Appeals for its alternative, due process holding on the right to treatment or to release:

> Taken, together, these . . . . cases constitute a near unanimous recognition that governments must afford a *quid pro quo* when they confine citizens in circumstances where the conventional limitations of the criminal process are inapplicable.

Id., at 524. In the face of the Court of Appeals' scholarly opinion, petitioner can only assert, without any analysis or citation of authority, that "it cannot be reasonably or responsibly argued that society does not have the right under the police power theory to

D. Definition of the Right to Treatment: The Trial Court Properly Instructed the Jury That Respondent Should Have Received Such Treatment As Would Have Given Him a Reasonable Opportunity To Be Cured or To Improve His Mental Condition

Relying on only a single case, which has been reversed,[62] and on a tiny minority of commentators,[63] petitioner claims that courts are incapable of defining or enforcing the constitutional right to treatment. Petr.

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confine mentally ill persons with a propensity for dangerous behavior, with or without accompanying treatment." Petr. Brief at 23-24.

The right to treatment or to release for all involuntarily confined mental patients is also compelled by the prohibition against cruel and unusual punishments contained in the Eighth and Fourteenth Amendments. While the due process right to treatment looks to the permissible state purpose justifying involuntary commitment, the right to treatment, when based on the guarantee against cruel and unusual punishments, stems from the conditions of confinement. Without treatment, a mental hospital is no more than a prison. *See* pp. 51-52 and note 51, *supra*. And a mentally ill person, confined without treatment, whether judged to have dangerous propensities or not, is being incarcerated as if his sickness were a crime. To so confine a person is unconstitutional. *Robinson* v. *California*, 370 U.S. 660, 666 (1962). And state authorities must, therefore, treat the patient or release him.

[62] *Burnham* v. *Department of Public Health*, 349 F.Supp. 1335 (N.D. Ga. 1972), *rev'd & remand*, No. 72-3110 (5th Cir. Nov. 8, 1974). *See* note 28, *supra*. *Burnham* is inapposite, at least in part, because the District Court did not think that the right to treatment could be enforced on an institution-wide basis but intimated that an inquiry into the adequacy of treatment could be made on an individual basis. 349 F.Supp. at 1343.

[63] See Petr. Brief at 30, n. 18 and 38-39, n.30. Not only does petitioner fail to acknowledge the broad range of legal and other commentary to the contrary, see notes 25-26, *supra*, but at least three of the five articles cited by petitioner do not stand for the proposition that the right to treatment is incapable of definition or enforcement but, in fact, conclude that it is ("Cameron" and "Katz") or are essentially non-committal on the point ("Note").

Brief at 29-45.[64] Petitioner maintains that, because there is a broad spectrum of expert opinion regarding proper treatment of the mentally ill, courts should, therefore, have no role in ensuring that involuntarily confined mental patients receive some treatment. *Id.* at 30-37, 43-44.[65]

But petitioner's arguments, once again, simply ignore the instructions and facts which make this case a narrow and easy one. In any event, respondent will demonstrate that courts can use the traditional methods of the judicial process in determining whether state officials are providing involuntarily confined mental patients with the reasonable level of treatment guaranteed by the Constitution.

1. *The instructions defining the right to treatment were correct.*

After ruling that a person civilly committed to a state mental hospital has a constitutional right to treatment or release, the Court of Appeals for the Fifth Circuit defined respondent's right to treatment in a holding that

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[64] The question of ascertaining judicially manageable standards for measuring the rights and duties of parties is customarily viewed as an issue of justiciability, *Baker* v. *Carr*, 369 U.S. 186, 198 (1962); *accord*, *Powell* v. *McCormack*, 395 U.S. 486, 518 (1969), although petitioner does not use this term in his brief. *See*, Comment, *Wyatt* v. *Stickney, and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282, 1296-99 (1973) (right to treatment is justiciable); *Developments—Civil Commitment*, *supra*, note 26, at 1333-44 (right to treatment is justiciable).

[65] Evaluation of the reasonableness of treatment would, petitioner asserts, "force" courts into the position of "picking and choosing" among various forms of treatment, thereby "overruling decisions of trained psychiatrists." Petr. Brief at 44.

But this far-reaching contention finds *no* support in the trial records. No witness testified that it was impossible, or even difficult, to define "treatment" or "reasonable treatment" for the purpose of enforcing the right to treatment in the courts.

followed the trial court's instruction: respondent should receive "such individual treatment as will give him a *reasonable* opportunity to be cured or to improve his mental condition." *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520. (Emphasis added.)[66] This instruction defining the right to treatment follows necessarily from the due process theory establishing that right. Because respondent's right to treatment arose when the state involuntarily confined him for the purpose of treating his alleged mental illness in order to restore him to the community, then the level of treatment provided should, in fact, have given respondent a reasonable opportunity to have that illness improved or cured. Otherwise, his confinement would have been wholly arbitrary.

Not only is the instruction defining the right to treatment logically compelled, but it is also strongly supported by this Court's requirement in *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738, that continued involuntary confinement by the state "must be justified by *progress* toward" the goal of that confinement. (Emphasis added.) This rule clearly justified scrutiny of the nature of the treatment provided in this case to ensure that it bore a reasonable relation to the purpose of confinement. *See Humphrey* v. *Cady*, *supra*, 405 U.S. at 514; *Murel* v. *City of Baltimore Criminal Ct.*, *supra*, 407 U.S. at 357-58. As the Supreme Judicial Court of Massachusetts has stated, *Nason* v. *Superintendent, Bridgewater Hospital*, 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968):

> "Confinement of mentally ill persons, not found guilty of crime, without affording them *reasonable* treatment also raises serious questions of deprivation of liberty without due process of law. As we said in the *Page* case, of a statute permitting comparable confinement, 'to be sustained as a non-penal statute . . . it is necessary that the *remedial aspect of confinement . . . have foundation in fact.*'" (Emphasis added; citations omitted.)

See also, Virginia Note, *supra*, at 616-19; Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282, 1286 (1973). When there is a "massive curtailment of liberty" in a constitutional sense, *Humphrey* v. *Cady*, *supra*, 405 U.S. at 509, for the purpose of treatment, then courts should review the actual treatment provided to ensure that it is reasonable; the decision whether the involuntary confinement of a mentally ill person continues to be valid after civil commitment, like the threshold decision to commit, is a "social and legal judgment," not just a medical one. *Id.*, at 509. *See also*, ABF Study, *supra*, at 171 (". . . it remains the function of law to circumscribe the decision-making powers of hospital officials.").

2. *The evidence showed, and the jury could have found, that respondent did not receive treatment, which would have provided a reasonable opportunity to cure or improve his mental condition.*

In this case, respondent sought damages for petitioner's failure to treat *or else* release him. Respondent did not seek the affirmative provision of treatment. This is, therefore, a narrow case. The jury could have found:

> First, petitioner *knew* that respondent was not getting any treatment and yet he refused to release him, although he knew respondent was dangerous neither to himself nor to others.[67]

[66] The Court of Appeals properly read the District Court's instruction that respondent had a right to "such treatment as will give him a realistic opportunity to be cured or to improve his mental condition" as a right to a "reasonable" opportunity to be cured or to improve. *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520.

When the trial judge announced in chambers that he intended to give the instruction, petitioner did not object. T 11/28/72 at 8.

[67] *See* pp. 5-19, *supra*.

> Second, petitioner specifically withheld from respondent available treatment resources—occupational therapy and grounds privileges, for example—for reasons unrelated to his treatment needs.[68]
>
> Third, *nothing* respondent received at Florida State Hospital (and respondent received no more than custodial care) would have given him a reasonable opportunity—in fact, *any* opportunity—to be cured or to improve his mental condition.[69]

Thus, as the Court of Appeals observed, this is a case in which the jury could have decided that respondent received *no* treatment without needing further guidance from the trial court as to the definition of treatment reasonably calculated to improve or cure respondent's mental condition. *Donaldson* v. *O'Connor*, *supra*, 493 F. 2d at 526.

3. *Standards defining the right to treatment can be developed in other cases by using the traditional tools of the judicial process.*

Petitioner's broad argument that there can be *no* definition of the constitutional right to treatment, and his additional claim that enforcement of this right will impair rather than advance the provision of mental health services to involuntarily confined patients, are without merit, as the endorsement of the right by the major, professional mental health organizations demonstrates. *See Amici Curiae* Briefs submitted in No. 74-8.[70] Courts can mediate successfully between two important interests: the right of involuntarily confined patients to receive a reasonable level of treatment and the need of mental health professionals to exercise their expertise

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[68] *See* pp. 10-14, *supra*.

[69] *See* pp. 5-14, *supra*.

[70] *See* note 25, *supra*.

within a wide range of discretion. And the constitutional right to treatment, properly understood, will not subject the vast majority of state doctors to personal liability.

Existing case law and commentary on the constitutional right to treatment demonstrates that broad and sensible guidelines for defining the right have already begun to develop. The fundamental theme of the precedent and the literature is that, when enforcing the right to treatment, courts will *not* attempt to prescribe specific forms of treatment for specific patients, but will limit their review to determining whether some form of treatment recognized by responsible professionals is being provided. In conducting that review, courts will ordinarily look to good faith efforts by state officials to provide treatment that is within the broad range of accepted professional practice. In reality, the right to treatment suits which have been brought to date—whether of a class or individual nature—have involved state hospital conditions or officials acts which were so substandard that there could be unanimity among responsible professionals and professional groups that a reasonable level of treatment was not being provided. *See, e.g.*, *Wyatt* v. *Aderholt*, *supra*, slip opn. at 722 (even defendants conceded that they were not providing reasonable treatment). *See also Welsch* v. *Likins*, 373 F. Supp. 487, 496 (D. Minn. 1974).

More specifically, the following guidelines for defining the right to treatment have emerged from both individual and class actions.

First, judicial enforcement of the right has not, thus far, required doctors to demonstrate that a particular course of treatment would cure or improve the patient's mental condition, but only to show that there was a *bona*

fide effort and a reasonable opportunity to cure or improve that condition.[71]

Second, courts have allowed state authorities broad discretion, within the range of present knowledge, in their efforts to treat the mentally ill.[72]

Third, courts have not required state officials to provide the "best possible treatment" but only treatment that is "adequate" or "reasonable" within the range of accepted professional practice.[73]

Fourth, courts can determine what is or is not accepted professional practice through published professional standards,[74] position papers of expert organiza-

[71] *See, e.g., Rouse* v. *Cameron*, 373 F.2d 451, 456-7 (D.C. Cir. 1966); *Wyatt* v. *Stickney, supra*, 325 F.Supp. at 785, *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974).

[72] *Rouse* v. *Cameron, supra*, 373 F.2d at 456 (government authorities have an obligation to provide treatment that comes within the range of "present knowledge").

[73] *Tribby* v. *Cameron*, 379 F.2d 104, 105 (D.C. Cir. 1967) (Edgerton, J.: "We do not suggest that the court should or should can decide what particular treatment this patient requires . . . We do not decide whether the [government] has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion."); *In re Jones*, 338 F.Supp. 428, 429 (D.D.C. 1972). *Cf. Dobson* v. *Cameron*, 383 F.2d 519 (D.C. Cir. 1967) (en banc) (Burger, J., concurring: ". . . it can be argued that Congress has conferred some power on us at least to inquire into civil commitment cases when it is alleged that one is being detained *without any* treatment."). (Emphasis added.)

[74] *See, e.g.*, Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972). The Joint Commission is comprised of members from the following organizations: American Academy of Child Psychiatry, American Association on Mental Deficiency, American Hospital Association, American Psychiatric Association, National Association of Private Psychiatric Hospitals, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers. *See also*, American Psychiatric Association, Standards for

tions,[75] and expert testimony.

Fifth, when evaluating the adequacy of treatment,[76]

Psychiatric Facilities (1974 ed.); American Psychological Association Task Force on Standards for Service Facilities, Standards for Providers of Psychological Services (1974).

[75] *See, e.g.*, American Psychiatric Association Task Force on the Right to Care and Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded (Oct. 1974); American Psychiatric Association, Position Paper on Involuntary Hospitalization of the Mentally Ill, 130 Am.J.Psychiatry (1973); National Association for Mental Health, Position Statement on the Right to Treatment (1970). Material on standards and adequate treatment is also found in such leading professional journals as The American Journal of Psychiatry, The Archives of General Psychiatry, The Journal of the American Medical Association, Mental Hygiene, The American Journal of Orthopsychiatry, Journal of Clinical Psychology and the Journal of Nervous and Mental Diseases.

[76] To date courts have not required state officials to prove that treatment has been "effective." *Cf.* Schwitzgebel, *The Right to Effective Mental Treatment*, 62 Cal. L. Rev. 936 (1974) (right to treatment should be measured by whether patient's mental illness *will be* cured or improved). There is, however, strong support for this further requirement in *Jackson* v. *Indiana, supra*. There, this Court unanimously ruled that continued confinement on the grounds of incompetence to stand trial could be justified only if there was "progress" toward the goal of restoring competence. 406 U.S. at 738. That ruling was consistent with, and perhaps required by, the Court's admonition in *Jackson* that not only the "nature" but also the "duration" of confinement must bear some reasonable relation to the purpose of confinement. That is, unless treatment is "effective" in the sense that there is "progress" towards cure or improvement, continued confinement would not bear a reasonable relation to the purpose of confinement. *Jackson* thus suggests a limited and indirect standard for reviewing the effectiveness of treatment. If, after a reasonable period of time, there has been "no progress" toward a permissible goal; the reviewing court could conclude that the treatment provided has not been effective, and therefore, that further treatment would not give the patient a "reasonable opportunity" for cure or improvement. *See also, McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 249-52 (1972), where this Court also imposed a due process time limit on confinement for observation.

courts can utilize *amici curiae*, ombudsmen or human rights committees.[77]

The workability of these guidelines is already evident in suits seeking *institution-wide relief*. For example, in *Wyatt* v. *Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971), *affirmed sub nom.*, *Wyatt* v. *Aderholt*, *supra*, a class action seeking declaratory and injunctive relief, the District Court held that there were three fundamental conditions which were necessary for adequate treatment of the civilly committed: (1) a humane psychological and physical environment; (2) qualified staff in numbers sufficient to administer adequate treatment; and (3) individualized treatment plans. In reaching this conclusion, the Court relied on extensive participation in the case by professional organizations and by the United States as *amici curiae*. These three conditions constitute professional and constitutional minima which must be met if the involuntarily confined patient's right to treatment is to be protected. These conditions have received wide endorsement.[78] And they reflect application of the

[77] National mental health organizations participated extensively in *Wyatt* v. *Aderholt*, *supra*, both at the trial level and on appeal. These groups were the American Orthopsychiatric Association, the American Psychological Association, and the American Association on Mental Deficiency (at trial and on appeal) and the American Psychiatric Association and the National Association for Mental Health (on appeal). As the Court of Appeals noted, "The District Court expressed its gratitude to these organizations for their valuable assistance in this difficult and complex case, 344 F. Supp. 375, 390, and we do so, too." *Id.*, slip opn. at 719 n. 3. *See generally*, *Developments—Civil Commitment*, *supra*, note 26, at 1340-41.

[78] There is widespread agreement among professional organizations active in the mental health area on the need for all three conditions as an absolute minimum, without which there can be no treatment reasonably calculated to improve or to cure patients' conditions.

With respect to staffing patterns there is consensus that adequately trained personnel in sufficient numbers is an essential component of treatment effectiveness. Specific staffing ratios can be set based on the goals of the individual facility, the types of patient served, geographic location and other factors. *See*, *e.g.*, American Psychiatric Association, Standards for Psychiatric Facilities (1974 Revision/Addendum) (Standard 14-A); American Psychiatric Association, Standards for Psychiatric Facilities (1969) (Standards 28, 30-32); Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972).

Similarly, there is universal agreement that a "humane physical and psychological environment" is a *sine qua non* of effective treatment. And indices have been developed with respect to nutrition, space, ventilation, bathing facilities and other aspects of a patient's daily life. *See*, *e.g.*, American Psychiatric Association, Standards for Psychiatric Facilities (1974 Revision/Addendum) (Principle B and Standard 21-A); American Psychiatric Association, Standards for Psychiatric Facilities (1969) (Standards 29, 39 and 44); Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972).

Finally, there is unanimity that individual treatment plans are necessary both for effective treatment of patients and for responsible review by mental health professionals (not simply courts) of the quality of care received by the civilly committed mentally ill (as well as other types of medical and psychiatric patients). Moreover, there is consensus on what general information should be included in such plans. *See*, *e.g.*, American Psychiatric Association, Standards for Psychiatric Facilities (1969) (Standards 10 and 34); Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972).

guidelines outlined above, since they look to objective professional standards in establishing intelligible constitutional standards which will leave substantial discretion in the hands of mental health professionals. Moreover, to facilitate judicial administration of the right to treatment, the *Wyatt* court confined itself to the "increasingly common procedure of permitting the parties to fashion their own relief and then reviewing its reasonableness." Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282, 1298-99 (1972). *See also*, *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974).

The guidelines also are workable with respect to *individual* actions seeking damages or an injunction prohibit-

ing provision of inadequate treatment. For example, if a mentally ill person were confined because of psychotic depression, the state authorities could choose from a wide range of professionally accepted treatments such as chemotherapy, psychotherapy, group therapy, or occupational therapy. A reviewing court would merely decide that the treatment in question was within a professionally accepted range of treatment modes when denying the patient's claim. However, if the patient was not being given any professionally recognized treatment, then relief might lie, assuming other legal requirements were satisfied.

Petitioner's arguments about the non-justiciability of the right to treatment and the "devastating effects" its recognition will have on the Florida mental health system are directly refuted by recent Florida legislation. The Baker Act provides for a right to individual dignity, a right to treatment and a definition of the quality of treatment for those who are involuntarily confined in state hospitals. Title 27 Florida Statutes § 394.459 (July 1, 1972).[79] Obviously, the Florida legislature—and many

[79] Section 394.459(1) provides, in part:

"(1) *Right to individual dignity*: The policy of the state is that the individual dignity of the patient shall be respected at all times and upon all occasions. . . . Treatment shall be provided to the patient by his physician or the receiving facility staff. No person who is receiving treatment for mental illness in a hospital shall be deprived of any constitutional rights."

Section 394.459(a) provides, in part:

"(2) *Right to treatment*:—The policy of the state is that the Department [of Mental Health] shall not deny treatment for any mental illness to any person. . . ."

Section 394.459(4) provides, in part:

"(4) *Quality of treatment*: (a) Each patient in a facility shall receive treatment suited to his needs, which shall be administered skillfully, safely and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational and rehabilitative services as his condition requires to bring about his early return to his community."

other legislatures as well—does not consider the right to treatment non-justiciable, and has established a statutory right to treatment which may, properly, be more expansive than the right to treatment required by the Constitution.[80]

In short, judicial administration of the right to treatment would be no more difficult than court supervision of many other issues involving psychiatry or medicine. *See generally*, J. Katz, J. Goldstein & A. Dershowitz, Psychoanalysis, Psychiatry and the Law (1967); R. Slovenko, Psychiatry and Law (1973). For example, civil commitment itself is based on the premise that the courts can recognize mental illness and determine that such illness requires treatment. "If the right to treatment is non-justiciable, however, it is hard to imagine how a court can initially decide that a person is in need of treatment or that a person would benefit from involuntary hospitalization." *Developments—Civil Commitment*, *supra*, at 1336, n.86. Moreover, it is obvious that courts are continuously involved in deciding legal questions with an important medical or psychiatric dimension, when there has not yet been "finality of judgment", *Greenwood*

In January 1974, William D. Rogers, Director of the Florida Division of Mental Health, promulgated a Manual of Rights of Patients to guide implementation of the new legislation. In that manual (at 15-16), Rogers states: "The hospitals and facilities of the Division are not punitive or merely custodial; they exist to provide quality treatment for those patients committed to them. *If a hospital fails to provide quality treatment, its reasons for being must be seriously questioned and certainly its legal justification for involuntary commitment disappears.*" (Emphasis added.)

For a discussion of the damages provision of the new law which imposes liability on state doctors, *see* pp. 84-85, *infra*.

[80] For a discussion of statutory right to treatment provisions, *see Developments—Civil Commitment*, *supra*, note 26, at 1319-24.

v. *United States*, *supra*, 350 U.S. at 375,[81] and which require reconciling state interests and individual rights in such areas as the insanity defense,[82] drug-related offenses,[83] the adequacy of medical care afforded prisoners,[84] conditions in prisons,[85] and malpractice.[86] *See Roe*

[81] Petitioner cites *Greenwood* for the proposition that there is not universal agreement among mental health professionals about what constitutes proper treatment. Petr. Brief at 34. But, as the right to treatment has been implemented in the lower courts, that perception has been taken into account. As has been discussed, *see* pp. 65-70, *supra*, to satisfy their duty to vindicate the right to treatment state officials need only provide a form of treatment that falls within a wide range of professionally accepted choices.

United States v. *Klein*, 325 F.2d 283, 286 (2d Cir. 1963), Petr. Brief at 33, is inapposite for the same reason. The issue in the case was whether a particular treatment might aid Klein in becoming competent to stand trial. The Court of Appeals stated that under 18 U.S.C. § 4246 courts did not have authority to choose which " of two equally *reputable methods* of psychiatric treatment would prove most efficacious in a particular case." *Klein*, *supra*, at 285. (Emphasis added.) When enforcing the constitutional right to treatment, courts would not make such decisions either.

[82] *See generally*, J. Katz, J. Goldstein and A. Dershowitz, *Psychoanalysis, Psychiatry and Law* 526-98 (1967); R. Slovenko, *Psychiatry and Law* 77-91 (1973); A. Goldstein, *The Insanity Defense* (1968).

[83] *See, e.g., Robinson* v. *California*, 370 U.S. 660 (1962); *Easter* v. *District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966); *Slovenko*, *supra*, note 82, 143-73.

[84] *See, e.g., Martinez* v. *Mancusi*, 443 F.2d 921 (2d Cir. 1970), *cert. denied*, 401 U.S. 983 (1971); *Blanks* v. *Cunningham*, 409 F.2d 220 (4th Cir. 1969).

[85] *See, e.g., Holt* v. *Sarver*, 442 F.2d 304 (8th Cir. 1971); *Landman* v. *Royster*, 354 F. Supp. 1302 (E.D. Va. 1973).

[86] *See, e.g., Whitetree* v. *State*, 56 Misc.2d 693, 290 N.Y.S.2d 486 ,Ct. Cl. 1968) ($300,000 in damages awarded to patient for confining him because of incompetence to stand trial and then failing to provide treatment). Petitioner claims that there are very few malpractice cases in the psychiatric area and that the courts have exhibited reluctance in trying to decide when negligence has occurred in treatment matters. Petr. Brief at 37. *But see*, R. Slovenko, *supra*, note 82 at 394-433 ("Psychiatric Tort and Other Liability"). D. Dawidoff, The Malpractice of Psychiatrists (1973).

v. *Wade*, 410 U.S. 113 (1973); *Doe* v. *Bolton*, 410 U.S. 179 (1973). And, more generally, it is obvious, too, that courts are often required to consider complex and technical matters in deciding a host of statutory and constitutional cases that affect competing interests.[87]

Accordingly, this Court should hold that respondent had a constitutional right to treatment or to release and that the trial court's instruction defining the right to treatment was correct in the circumstances of this case. Standards governing further definition of the right can be developed, on a case by case basis, by those federal and state courts which are called upon to consider claims involving alleged deprivation of the constitutional right to treatment. By so holding, this Court can ensure that the most basic liberties of vulnerable individuals—those who are involuntarily confined for mental illness—are accorded the reasonable protection that the Constitution guarantees.

Finally, it should be emphasized that a state official's failure to provide treatment will not of itself subject the official to liability in damages. Habeas corpus actions or actions seeking declaratory and injunctive relief will ordinarily serve to vindicate individual rights. As will be discussed in Part II, *infra*, damages will only lie in those hopefully rare instances when the judge or jury finds that, as here, the state official both denied the right to treatment or release and failed to act in good faith.

[87] *See generally*, L. Tribe, Channeling Technology Through Law (1973). When the state intrudes upon constitutionally protected liberties, the intrusion raises social and legal questions and is not simply to be left to the uncontrolled discretion of experts.

II. IN THE CIRCUMSTANCES OF THIS CASE, THE AWARD OF COMPENSATORY AND PUNITIVE DAMAGES SHOULD BE AFFIRMED

Under the instructions in this case, in order to award damages, the jury had to find (a) that petitioner knew respondent was not dangerous;[88] (b) that petitioner knew respondent received only custodial care;[89] *and* (c) that petitioner did not reasonably and in good faith believe that respondent's continued confinement was lawful.

The judge instructed the jury as follows (A at 184):

> "If the Jury should believe from a preponderance of the evidence that the Defendants *reasonably believed in good faith* that detention of Plaintiff was proper for the length of time he was so confined then a verdict for Defendants should be entered *even though the jury may find the detention to have been unlawful.*
>
> "However, mere good intentions which do not give rise to a *reasonable belief that detention is lawfully required* cannot justify Plaintiff's confinement in the Florida State Hospital." (Emphasis added.)

Thus, under the instructions, before awarding damages the jury had to find that respondent's continued confinement was unlawful *and* that petitioner *knew* it was unlawful.

[88] *See*, p. 39, *supra*.

[89] *See*, p. 40, *supra*.

A. No Legal Issue Regarding Damages Is Before This Court Because Petitioner Did Not Object to the Relevant Jury Instructions, Either at Trial or on Appeal

1. *The good faith and reasonableness defense.*

As the Court of Appeals noted, "the trial judge instructed the jury to find for the defendants if it found the defendants acted in good faith; and . . . the defendants have not challenged the propriety or phrasing of this instruction." 493 F.2d at 530. Although petitioner does challenge the sufficiency of the evidence to support the verdict, he did not object to that instruction below, nor does he challenge it here.[90]

Moreover, under the instructions relating to the award of *punitive* damages, the jury was required to find not only that petitioner did not reasonably and in good faith believe respondent's confinement was lawful or proper, but also that petitioner's acts constituted "extraordinary misconduct" and were "malicious, wanton or oppressive." T Oral Charge 11/28/72 at 16-18. Again, petitioner did not object to this instruction as given below and does not challenge its correctness here. T 11/28/72 at 54-56.

[90] Although petitioner and his co-defendants did not object to the damages instructions that *were* given, they did object to the trial court's refusal to give an additional instruction that would have entitled them to claim "quasi-judicial immunity." Defendants' Proposed Instruction No. 11 read: "If you find that the defendants were operating in a quasi-judicial function, in that they, under state law, were making a judgment as to whether or not plaintiff should be released, defendants are immune from liability under the Civil Rights Act." In an Instructions Conference in chambers, that proposed instruction was refused. T 11/28/72 at 10. Petitioner did not appeal the refusal to give that instruction. His co-defendant John Gumanis did appeal that issue. 493 F.2d at 529. The Court of Appeals ruled that state hospital officials are entitled to claim good faith as a defense but are not entitled to claim quasi-judicial immunity, and that the refusal to give the proposed instruction was therefore proper. 493 F.2d at 529-30. Petitioner has not raised the refusal to give a "quasi-judicial immunity" instruction as an issue in this Court.

2. *The "retroactivity" claim.*

The only *legal* issue regarding damages raised by petitioner in this Court is his claim that the award is based on "the retroactive application" of a newly declared right. Petr. Brief at 16. Petitioner *did not raise this claim at trial, and it was not raised, briefed or argued on appeal.*[91] There is no discussion of this claim in the opinion below. Accordingly, there is no legal issue regarding daamges properly before this Court.[92]

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[91] At no point during the trial did petitioner seek to introduce evidence that would provide factual support for a retroactivity claim, and there is no such evidence in the record. The closest petitioner came to addressing this point was Defendants' Proposed Instruction No. 15, which provided: "You are instructed that if defendants acted pursuant to a statute which was not declared unconstitutional at the time, they can not be held accountable for such action." During the Instructions Conference in chambers, the trial judge announced that he would not give that instruction. T 11/28/72 at 11. Petitioner did not object to that refusal. *Id.* The refusal was quite proper, first, because the substance of the instruction was covered in the good faith instructions which the court did give, and second, because there was literally no evidence that petitioner believed or even claimed that he was required or authorized by any statute to continue to confine a non-dangerous patient who was receiving no treatment.

[92] As stated in *Lawn* v. *United States*, 355 U.S. 339, 362, n. 16 (1958), *rehearing denied*, 355 U.S. 967 (1958), "Only in exceptional cases will this Court review a question not raised in the court below." *See also*, *Adickes* v. *S. H. Kress and Co.*, 398 U.S. 144, 147, n. 2 (1970); *Duignan* v. *United States*, 274 U.S. 195, 200 (1927), and cases cited therein; and *Husty* v. *United States*, 282 U.S. 694, 701-02 (1930). Although a party may raise a constitutional question for the first time in this Court it is clear that the retroactive or prospective application of a ruling in itself raises no constitutional questions: "[T]he federal constitution has no voice upon the subject." *Great No. Ry.* v. *Sunburst Oil & Refining Co.*, 287 U.S. 358, 364 (1932) (Mr. Justice Cardozo); *accord*, *Linkletter* v. *Walker*, 381 U.S. 618, 629 (1965) ("[T]he Constitution neither prohibits nor requires retrospective effect.").

B. The Jury Instructions Relevant to the Award of Damages Were in Accord With Applicable Law

Even assuming, *arguendo*, that legal issues regarding damages are properly before this Court, respondent will demonstrate in this section that the award of damages was in accord with applicable law.

1. *The good faith and reasonableness defense.*

Under the civil rights acts only legislators and judges have absolute immunity. *Tenney* v. *Brandhove*, 341 U.S. 367, 376-77 (1951) (legislators); *Pierson* v. *Ray*, 386 U.S. 547 (1967) and *Bradley* v. *Fisher*, 80 U.S. 335, 347-49 (1871) (judges). As petitioner rightly concedes, "state officers and employees are not entitled to the absolute immunity accorded the judiciary, because that would frustrate the intent of Title 42 U.S.C. § 1983 . . . state employees and administrators should be required to act as reasonable and responsible men. . . ." Pet. for *Cert.* at 39; *see also*, Petr. Brief at 54. A "qualified immunity" is, however, available to officers or employees of the executive branch. And the breadth of this defense depends upon "the scope of discretion and responsiblities of the office and all the circumstances as they reasonably appeared at the time of the action on which liability is sought to be based." *Scheuer* v. *Rhodes*, 416 U.S. 232, 247 (1974).

The trial court decided on the wording of the "good faith" instruction after carefully reading *Pierson* v. *Ray*, *supra* (T 11/28/72 at 49), and the instruction parallels the language of that case with notable fidelity. *Pierson* involved police officers who were alleged to have falsely arrested and imprisoned petitioners in deprivation of their civil rights. This Court held (386 U.S. at 557):

> ". . . if the jury found that the officers *reasonably* believed *in good faith* that the arrest was constitutional, then a verdict for the officers would follow

even though the arrest was in fact unconstitutional." (Emphasis added.)

Here the jury was instructed that if petitioner reasonably believed in good faith that respondent's confinement was lawful, a verdict for petitioner would follow even though his confinement was in fact unlawful.

This dual requirement of good faith and reasonableness has been consistently applied by this Court. In *Scheuer* v. *Rhodes*, *supra*, for example, this Court delineated the potential liability in damages of a state Governor who was acting within the broadest possible range of discretion, during what he believed was an emergency. And even in those circumstances, this Court held:

> "[I]t is the existence of *reasonable grounds* for the belief formed at the time and in light of all the circumstances, coupled with *good faith belief* that affords basis for qualified immunity of executive officers." 416 U.S. at 247-48. (Emphasis added.)

No broader defense is appropriate here. To the contrary, petitioner properly received the same qualified immunity based upon good faith and reasonableness which has been considered sufficient to protect such executive employees and administrators as: police officers, *Pierson*, *supra*; university officials, *Handverger* v. *Harvill*, 479 F.2d 513, 516 (9th Cir. 1973), *cert. denied*, 414 U.S. 1072; FBI agents, *Jones* v. *Perrigan*, 459 F.2d 81, 83 (6th Cir. 1972) and *Bivens* v. *Six Unknown Named Agents*, 456 F.2d 1339, 1341 (2d Cir. 1972); town officials, *Harrison* v. *Brooks*, 446 F.2d 404, 407 (1st Cir. 1971); directors of state departments of mental health and program coordinators on wards, *Wheeler* v. *Glass*, 473 F.2d 983, 985 (7th Cir. 1973); directors of state institutions for "defective delinquents," *Mitchell* v. *Boslow*, 357 F.Supp. 199, 202-03 (D.Md. 1973); court clerks, *McCray* v. *Maryland*, 456 F.2d 1, 5-6 (4th Cir. 1972);

and governors, *Scheuer*, *supra*. Thus, because petitioner does not challenge the legality of the instructions regarding the good faith and reasonableness defense, and because the instruction given comports fully with the relevant precedent, petitioner's objection to the verdict can only be with the sufficiency of the evidence (see discussion in section II.C., *infra*).

2. *The "retroactivity" claim.*

Petitioner's assertion, raised now for the first time, that he "should not be held personally liable for the deprivation of a constitutional right [to treatment], whose emergence and enforcement could not have been reasonably foreseen" (Petr. Brief at 52)[93] has no rele-

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[93] In § 1983 damage actions, it is well established that state officials can be held liable for deprivation of constitutional rights that had not previously been declared, but the emergence of which could reasonably have been foreseen. *See*, *Adickes* v. *S. H. Kress and Co.*, *supra*, at 232-33 (Brennan, J., concurring in part and dissenting in part):

> "I think it just and faithful to the statutory purpose to impose the loss on the discriminator, even if he was unaware that his discrimination constituted state action denying equal protection. Proof of an evil motive or of a specific intent to deprive a person of a constitutional right is generally not required under § 1983 [citing cases]. And, indeed, in *Nixon* v. *Herndon*, 273 U.S. 536, 47 S. Ct. 446, 71 L. Ed. 759 (1927), and *Lane* v. *Wilson*, 307 U.S. 268, 59 S. Ct. 872, 83 L. Ed. 1281 (1939), this Court upheld complaints seeking $5,000 recoveries from state election officials who merely carried out their official duty to prevent the plaintiffs from voting under discriminatory state statutes which made them ineligible to vote."

See also, *Landman* v. *Royster*, 354 F. Supp. 1302, 1317 (E.D. Va. 1973) ($21,000 judgment against Director of Division of Corrections for causing prisoners physical and psychic damage in violation of their constitutional rights); *Wheeler* v. *Glass*, 473 F.2d 983, 985 (7th Cir. 1973) (damage action by two retarded persons for having been spreadeagled on bed for 77½ hours in violation of their Eighth Amendment rights because of alleged homosexual act); *Jobson* v. *Henne*, 355 F.2d 129 (2d Cir. 1966) (damage action for involuntary servitude by retarded resident

against director and assistant directors of state school); *Anderson* v. *Nosser*, 456 F.2d 835 (5th Cir. 1972) (superintendent of prison liable for imposing summary punishment on prisoner in violation of due process); *York* v. *Story*, 324 F.2d 450, 456 (9th Cir. 1963) (female plaintiff's allegations of violations of right to privacy by police officers taking intimate photos stated cause of action under § 1983); *Wright* v. *McMann*, 460 F.2d 126, 129 (2d Cir. 1972) (prison warden could be held personally liable under Eighth Amendment for leaving prisoner in unsanitary strip cell without clothing or elements of basic hygiene); *Winters* v. *Miller*, 446 F.2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971) (damage action by Christian Scientist mental patient against hospital staff for violation of First Amendment rights by enforced medication).

On the other hand, the reasonable belief and good faith defense applied in § 1983 cases would certainly protect public officials who had *reasonably* relied on existing legal or professional standards that were later found to be in violation of the Constitution. Notably, when a party has been insulated from damages because he reasonably believed his actions (later ruled unconstitutional) were lawful, reliance of the party on a prior ruling or regulation or custom has been an important part of the reasonable belief defense. *Huotari* v. *Vanderport*, 380 F.Supp. 645, 651 (D.Minn. 1974) (reliance on statute permitting warrantless arrest); *Taylor* v. *Perini*, 365 F.Supp. 557 (N.D. Ohio 1972) (reliance on "statutes, regulations and procedures which he believed entirely proper" in putting plaintiff in solitary prior to transfer); *McKinney* v. *DeBord*, 324 F.Supp. 928 (E.D. Cal. 1970) (reliance on prison regulation); *Kirstein* v. *Rector & Visitors of the University of Virginia*, 309 F.Supp. 184 (E.D. Va. 1970) (reliance on standard college admission procedure).

In this case, however, petitioner has cited no evidence, and there is none, that he relied on any established legal or professional standards to justify the continued confinement of respondent, a non-dangerous patient who was receiving no treatment. In his brief at 11-12, petitioner refers to various habeas corpus proceedings, usually *pro se*, initiated by respondent. Despite numerous attempts, respondent never succeeded in obtaining a hearing on his contentions that he had been illegally committed, was not mentally ill or dangerous, and received no treatment. So far as respondent's counsel have been able to determine, all of those proceedings were dismissed on jurisdictional, procedural, or other non-constitutional grounds not relevant to the issues before this Court. Petitioner does *not* assert, nor could he given the nature of those dismissals, that he relied upon those dismissals to justify his knowing deprivation of respondent's constitutional right to liberty.

vance to the facts of this case or to the instructions given to the jury. Petitioner was *not* held liable because he failed or was unable to provide respondent with treatment, but because petitioner "*confined* plaintiff against his will, *knowing* that he was not mentally ill or dangerous or *knowing* that if mentally ill he was *not receiving treatment* for his alleged mental illness." A at 183. (Emphasis added.) It was petitioner's failure to *release* respondent, knowing he was not receiving treatment—the stated purpose justifying the confinement—which created liability. Thus, petitioner's claim that because of the limited resources of Florida State Hospital he could not provide treatment, or adequate treatment, is irrelevant. If he had not had the power to *release* respondent, then petitioner's failure or inability to *treat* respondent would not have subjected him to liability under the instructions in this case. The constitutional right petitioner abridged, the right to liberty—the right to be free from unjustified restraint—is not a new or novel right. It is perhaps the oldest and most fundamental right of civilized man. He who continues to deprive another of liberty always bears the risk of liability if he fails to justify that continuing deprivation. *Bolling* v. *Sharpe*, 347 U.S. 497, 499-500 (1954); *Whirl* v. *Kern*, 407 F.2d 781 (5th Cir. 1969), *cert. denied*, 396 U.S. 901 (1969). Under the instructions in this case, the burden of justification would have been met if the jury had found either that respondent was dangerous (or that petitioner reasonably believed him to be dangerous) (A at 186); that respondent was receiving some form of treatment other than "mere custodial care" (A at 186), *or* that petitioner "reasonably" believed that respondent's confinement was "lawfully required." A at 184.

Furthermore, the theory under which this case was actually tried—that, absent treatment, respondent had a constitutional right to be *released*—did not seem "novel"

to petitioner. To the contrary, one of the instructions proposed by petitioner, but refused by the court on the ground that it was already covered (T 11/28/72 at 9), would have authorized the jury to find a *constitutional* violation if they believed petitioner confined plaintiff knowing he was not receiving treatment, and "adequate" treatment, at that (Defendants' Proposed Instruction No. 8):

> "If you believe that defendants, without fault of plaintiff, withheld psychiatric treatment from plaintiff, *or allowed his confinement to continue knowing that he was not receiving adequate treatment*, you may find that his confinement was illegal under the federal constitution and the Civil Rights Act." (Emphasis added.)

Finally, the jury found not only that petitioner obstructed respondent's release without a reasonable belief in the legality of his conduct, but also that petitioner acted "maliciously or wantonly or oppressively" (T Oral Charge 11/28/72 at 16-18), and the Court of Appeals agreed that the evidence justified the award of punitive damages. 493 F.2d at 531. The jury finding that petitioner's conduct "maliciously or wantonly or oppressively" injured respondent vitiates any possible claim by petitioner that he subjectively, let alone "reasonably," believed his conduct to be lawful.

Thus, petitioner cannot claim surprise that his acts resulted in liability, and there is no valid retroactivity issue in this case.

C. The Award of Compensatory and Punitive Damages Is Supported by the Evidence

As noted, the jury found that petitioner *knew* that liberty is a constitutionally protected right, and *knew* that he had deprived respondent of liberty without lawful justification.[94]

Petitioner's rhetoric about his good faith and about the unfairness of the jury verdict is misplaced in view of the jury's finding, affirmed by the Fifth Circuit, that petitioner acted "maliciously, wantonly or oppressively," in blocking respondent's release to responsible and interested friends and organizations. 493 F.2d at 515, 531, and generally at 510-18.[95] The many facts supporting the jury's award have been set forth at pp. —— above.

The trial judge, who was most familiar with the facts, denied petitioner's post-trial motion for a directed verdict and for a new trial, in which petitioner alleged that the evidence did not support the award. Accord-

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[94] So important is liberty that federal courts have ruled that damages can be awarded against state officials who illegally deprive others of liberty *even though* such officials did not, in fact, know the confinement was unlawful, and even though the confinement was for a much shorter period of time than that involved in this case. *See e.g., Whirl* v. *Kern*, 407 F.2d 781 (5th Cir. 1969), *cert. denied*, 396 U.S. 901 (1969), in which plaintiff sought damages from a sheriff who had kept him in jail for nine months after dismissal of indictments for two felonies, even though the sheriff alleged he did not know the indictments had been dismissed:

> "Ignorance . . . by a jailer should not vitiate the rights of a man entitled to his freedom. . . . The law does not hold the value of a man's freedom in such low regard." 407 F.2d at 792.

Certainly, therefore, in this case, where petitioner "knew" the confinement was unlawful, damages are justified.

[95] The question whether an objective or subjective standard is appropriate in assessing a defendant's "good faith effort" is now pending before the Court in *Wood* v. *Strickland, cert. granted*, 42 U.S.L.W. 3584 (U.S. No. 73-1285, April 15, 1974). In respondent's view, the jury finding of maliciousness in this case would support a finding of lack of good faith and reasonableness under either an objective or a subjective standard.

ingly, four federal judges have reviewed the record and have found ample evidence to support the award.

Petitioner advances no reason why this Court should again review the sufficiency of the evidence;[96] but if it does, it should affirm.

D. Affirmance of the Award of Damages Will Not Disrupt Florida's Mental Health System

Petitioner contends that if the verdict is affirmed, "competent staff will be driven away from inadequate institutions. . . ." Petr. Brief at 29.[97] In fact, however, affirmance will not disrupt the operation of Florida's mental health system, because Florida now provides, by statute, a right to treatment[98] and a civil damages remedy for persons confined without treatment. The Baker Act provides liability in damages for mental health professionals who do not act in "good faith in compliance with the provisions" of the Act:

> "(12) LIABILITY FOR VIOLATIONS—Any person who violates or abuses any rights or privileges of patients provided by this act *shall be liable for*

[96] *See*, n. 49, *supra*, for authority on the very limited scope of this Court's review of facts.

[97] A similar contention is raised in the Brief *Amicus Curiae* of American Psychiatric Association. But see the comments of the Second Circuit in *Wright* v. *McMann*, *supra*, at 135, in which a prison warden who was assessed damages under § 1983 made an analogous claim:

> "We are not moved by the suggestion that if we uphold liability today competent persons tomorrow will refuse to become superintendents, as the title is presently designated. In the unlikely event that a prospective superintendent in fact turns down an offer for fear of personal liability, we think that the position is probably better filled by someone determined to supervise the facility so as to prevent [constitutional deprivations]. . . ."

[98] *See*, text at pp. 70-71, and note 79, *supra*.

> *damages* as determined by law. A physician . . . or hospital officer or employee . . . who acts *in good faith in compliance with the provisions of this part*, shall be immune from civil or criminal liability for his actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility." Title 27, Florida Statutes Annotated, §§ 394.459(3)(a), and (12). (Emphasis added.)

Under the Baker Act, state hospital employees in Florida are already subject to a greater risk of liability than they would be under the jury instructions in this case.[99] Thus, petitioner cannot reasonably contend that affirmance of the verdict in this case will discourage psychiatrists from working in Florida mental hospitals.[100]

E. Petitioner's "Waiver" Argument Is Not Properly Before This Court, and Is Without Merit

Petitioner contends that respondent refused certain forms of treatment and therefore "by word and deed, effectively waived his right to treatment." Petr. Brief at 15. That contention was embodied in Defendants' Pro-

[99] Furthermore, in January of 1974, William D. Rogers, Director of the Florida Division of Mental Health and a defense witness in this case, promulgated a *Manual of Rights of Patients* designed to implement the Baker Act. This manual provides that "the hospitals and institutions of the Division are not punitive or merely custodial; they exist to provide quality treatment for those patients committed to them." Manual at 17-19. To avoid liability in actions for violations of patients' rights, physicians must show that they have acted in "good faith" in "compliance with" the manual. *Manual* at 3.

[100] The modern trend is for states to provide, by statute, that treatment is one of the "rights" of patients, and to further provide a statutory right to sue for damages whenever that right, or any right, is abridged. *E.g.*, Ga. Code Ann. (1971), §§ 88-502.3 and 88.502.18; Ariz. Leg. Serv. (1973) (Ch. 185) §§ 36-518 and 36-523; and Conn. Gen. Stat. Ann. (Supp. 1974) §§ 17-206c and 17-206h. *See also*, D.C. Code Ann. §§ 21-562 and 21-591 (1973), which provides criminal penalties for persons who deny patients' rights, including the right to treatment.

posed Instruction No. 4.[101] During the chambers discussion of that instruction, the court suggested adding the words "during such periods of time that he refused such treatment." T 11/28/72 at 6. Petitioner's attorney agreed: "Yes, I think that is appropriate." *Id.* The charge as given read as follows (T Oral Charge 11/28/72 at 11-12):

> "You are instructed that if Plaintiff through his own actions contributed to the withholding of a particular form of treatment, that Plaintiff is not entitled to collect compensation from the Defendants for the failure to give such treatment during the particular period or periods Plaintiff refused such treatment."

The only portion of the instruction that petitioner did not either propose or explicitly accept was the phrase "a particular form of" which, for present purposes, seems immaterial.

Furthermore, petitioner did not raise, brief or argue this "waiver" or "refusal of treatment" point on appeal.[102] The point was raised on appeal by his co-defendant Gumanis, but as the Court of Appeals noted, even Gumanis did not at trial or on appeal object to the instruction. 493 F.2d at 531. Thus, there is no legal issue respecting petitioner's waiver argument properly before this Court. After a review of the sufficiency of the evidence, the United States Court of Appeals found "no reason to believe that either the verdict or the award of damages was based upon the failure to give Donaldson those forms of treatment he refused." 493 F.2d at 531. Accordingly, there is simply nothing left on the waiver issue for this Court to review.[103]

[101] The instruction, as initially proposed, provided: "You are instructed that if plaintiff through his own actions contributed to the withholding of treatment, that plaintiff is not entitled to collect compensation from defendants for failure to give such treatment."

[102] In the Reply Brief for Petitioner at 2, petitioner concedes that the waiver point was only "raised on appeal by the co-defendant Gumanis. . . ."

[103] Furthermore, the jury could have found that respondent never in fact did refuse either electro-convulsive therapy or drug therapy, which were the only two forms of therapy petitioner ever alleged that respondent refused. Petitioner's contention that respondent "consistently" and "continually" refused shock therapy (Petr. Brief at 5-6, 49, 50), finds no support in the record. In fact, there is no evidence in the record that respondent ever actually "refused shock therapy." It is true, as petitioner points out, that at the time of his admission, respondent "requested" that no shock therapy be administered. (Petr. Brief at 5), but a request that shock not be administered is different from a refusal. Dr. C. H. Adair, who had procured the consent of respondent's parents to shock therapy should it be necessary (H at 163), testified that he had no recollection that respondent had ever "refused" shock therapy. A at 145; T 11/27/72 at 138. Dr. Adair further testified that ". . . I don't think it [shock treatment] was particularly indicated . . . I probably wouldn't have given it to him anyhow, whether he refused it or not, under any conditions." A at 145; T 11/27/72 at 138.

There was further evidence from which the jury could have concluded that petitioner never believed drugs were either necessary or appropriate for respondent. Petitioner never tried to persuade respondent of the value of drugs, and never told respondent what he thought medication would do to improve respondent's condition. A at 52; T 11/22/72 at 257. When respondent was transferred to the care of Dr. Hanenson late in his stay at Florida State Hospital, Dr. Hanenson actually gave respondent medication but discontinued it after about two weeks. A at 202(b)(i); H at 70. From this and other evidence in the record (A at 52; T 11/22/72 at 257), the jury could have concluded that respondent did not actually refuse drugs, and that in 1967 he even accepted them when, for the first time, they were actually prescribed, but that drugs apparently had little or not effect on his mental condition, and were, therefore, discontinued.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals for the Fifth Circuit should be affirmed.

Respectfully submitted,

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